Helping People of South Asian Origin to Stop Using Smokeless Tobacco: Fieldwork Report

National Institute for Health and Clinical Excellence

30th April 2012

Update information

November 2021: NICE guideline PH26 (June 2010) has been updated and replaced by NG209.

This guideline contains the evidence and committee discussion for recommendations from PH26 dated [2010] and [2010, amended 2021].

See www.nice.org.uk/guidance/NG209 for all the current recommendations and the evidence behind them.

Helping People of South Asian Origin to Stop Using Smokeless Tobacco: Fieldwork Report

National Institute for Health and Clinical Excellence

A report submitted by GHK

Date: 30th April 2012

Dr Nahid Ahmad
GHK Consulting Ltd
30 St Pauls Square
Birmingham B3 1QZ
0121 233 8900

nahid.ahmad@ghkint.com
www.ghkint.com

Document control

Document Title	Helping People of South Asian Origin to Stop Using Smokeless Tobacco: Fieldwork Report
Prepared by	Dr Nahid Ahmad and Oliver Jackson
Checked by	Dr Shane Beadle
Date	30th April 2012

Contents

Executive summary

The use of smokeless tobacco carries significant health risks. South Asian groups are most likely to use these products; the highest prevalence rates are reported for those of Bangladeshi descent, with 16% of Bangladeshi women and 9% of Bangladeshi men in England chewing tobacco containing products.[1] Supporting people of South Asian origin to stop using smokeless tobacco requires a sound understanding of the types of products used by different community groups, and the cultural context of the behaviour.

The Department of Health asked the **Centre for Public Health Excellence (CPHE)** at the National Institute for Health and Clinical Excellence (NICE) to develop guidance on supporting South Asians to stop using smokeless tobacco. The draft guidance with six specific recommendations was developed by the **Public Health Interventions Advisory Committee (PHIAC).** It is aimed at a wide range of stakeholders with public health as their remit, including service providers; commissioners; managers; health professionals; and voluntary and community groups, as well as schools and members of the community.

GHK Consulting Ltd (GHK) was commissioned by the CPHE to field test the draft recommendations for helping people of South Asian origin to stop using smokeless tobacco.

The overall aim of the fieldwork was **to capture stakeholder views on the recommendations in terms of how relevant, usable, acceptable, and implementable they thought they were**. Seven specific questions were asked to meet this overall aim:

1. What are the views of commissioners, managers and practitioners, on the relevance and usefulness of the recommendations, to their current practice?

2. What factors could either help or hinder the effective implementation and delivery of the recommendations, as part of current practice?

3. What are the potential consequences of the recommendations for improving health and tackling health inequalities?

4. What is the potential impact of the recommendations on current policy, service provision or practice?

5. Which of the recommendations are both feasible and likely to make a difference to practice?

6. What would be the relative priority of each of the recommendations?

7. Do the potential relevance, usefulness, consequences, and impact of these recommendations differ between South Asian groups?

Feedback was gathered from 73 stakeholders in England, who participated in focus groups, telephone interviews, and an online survey. A range of participants took part in the fieldwork, including public health specialists, health professionals, and representatives from local authorities and voluntary sector groups.

In general stakeholders were supportive of the recommendations

The guidance was welcomed by stakeholders who thought the publication of them was an important step towards raising the profile of smokeless tobacco use. Comparisons to the progress of smoking as a public health concern were regularly made, and it was felt that there is a lack of general knowledge and awareness of smokeless tobacco use, amongst both professionals and the wider community.

[1] Health Survey for England (2004).

Stakeholders thought the guidelines were clear, but noted some gaps

Most stakeholders found the guidance to be clear and understandable. In general the recommendations were described as useful in setting out expectations for the key players: commissioners, funders, health practitioners, educators, and specialist cessation services. Particular gaps noted throughout included the following:

- There is no reference to the new structures which will become responsible for public health post-2013 – Clinical Commissioning Groups (CCGs) and Health and Well-being boards (HWBs) in particular should be specified in the target audiences for the recommendations.

- It was thought that the guidance could link better with relevant policy and other guidance throughout the recommendations.

Recommendation 1: Assessing local need

Feedback for this recommendation included that it is a necessary first step, which will help raise the profile of smokeless tobacco use as a public health risk. It was thought that the potential for impact is high if this recommendation is able to be successfully implemented. However it was stated that an accurate reflection of 'need' will be difficult to achieve, and that low knowledge levels and funding are key barriers to implementing this recommendation. Some stakeholders also thought that this recommendation required more detail in relation to the specific roles of different professional groups.

Recommendation 2: Working with local South Asian communities in areas of identified need

This recommendation was considered to be necessary for communicating the health message of smokeless tobacco use. The target audiences were thought to be appropriate, but it was thought that more detail was required to differentiate roles of different professionals.

The principal of community involvement was welcomed by all stakeholders. The voluntary and community sector was seen as an important 'way in' to working with local communities, and religious institutions in particular were noted as an important lever for raising awareness. In contrast, culture was noted as a key challenge as the use of smokeless tobacco products is embedded in cultural practice.

Recommendation 3: Planning and providing services in areas of identified need

This recommendation was not easily understood. There was confusion about who it is intended for, whether it is a recommendation about planning or providing services, and what service structures are being recommended. References to the Joint Strategic Needs Assessment (JSNA) and HWBs were noted as gaps in target audiences. A number of changes were suggested for recording outcomes:

- More guidance on who should be recording outcomes;
- Amend quit attempt targets - more intensive work with these groups (in comparison to smokers) means that lengthy follow ups will be difficult to achieve;
- Clarification of 'adverse effects'; and
- Include reference to including outcomes in provider contracts.

Recommendation 4: Providing brief advice and referral: dentists, GPs, pharmacists and other health professionals

General feedback for this recommendation was that it is very useful and relevant. Stakeholders had a good understanding of what 'brief intervention' is. Some said that this recommendation supported recommendation 1 of assessing need. Health professionals felt that this recommendation could be implemented easily, and that it fits with a broader set of health questions they already ask patients. It was thought that this recommendation supports the integration of smokeless tobacco services within mainstream services for smoking cessation. Key barriers to implementing the recommendation were noted as practitioner time, motivation and knowledge.

Recommendation 5: Training for practitioners

This recommendation was welcomed, and training was recognised as a key gap in most areas. Target audiences were thought to be in need of better clarification; three roles were identified in relation to training which are not currently evident in the recommendation:

1) Commissioners of training;
2) Deliverers of training; and
3) Receivers of training.

Finally it was thought that training should be standardised – although adaptable locally – to ensure consistent quality.

Recommendation 6: Specialist cessation services in areas of identified need

Whilst this recommendation was thought to be relevant and potentially practical, it was thought that more detail is required on the nature of services and how these should be commissioned. Some specific details of the recommended service were questioned, namely the following:

- The use of language specific material was also questioned by some (but not all); it was noted that many people who cannot read English have low literacy skills in their own languages also.
- Home visits were deemed to be too costly for the reach achieved from these.
- It was thought that validating quits will be too difficult to implement; in particular the cost of cotenine testing kits was raised as a barrier.

Implications for NICE

Feedback from stakeholders highlights some key implications for NICE:

- Stakeholder response to the guidance has shown that it is needed in order to both raise awareness and improve provision for South Asian users of smokeless tobacco.
- Knowledge and understanding is still low among those stakeholders for whom supporting smokeless tobacco use is part of their job. NICE needs to be aware of this and recognise that product-related knowledge in particular will need to be disseminated and kept updated in support of this guidance.
- Because of the comparatively low awareness of smokeless tobacco use, dissemination of the guidance needs to be wide, including as audiences frontline workforces, as well as managers and commissioners of services.
- Funding constraints present a significant barrier for implementing the guidance. In the absence of national funding the implementation of this guidance is much more vulnerable to variation between local areas.

1 Introduction

1.1 Overview and purpose of the fieldwork

GHK Consulting Ltd (GHK) was commissioned by the Centre for Public Health Excellence (CPHE) at the National Institute for Health and Clinical Excellence (NICE) to field test draft recommendations for helping people of South Asian origin to stop using smokeless tobacco.

The aim of field testing is to gather stakeholder views on whether and how the advice can be improved. This report presents the findings of the field work to test the recommendations with a range of stakeholders from public health, primary care, and voluntary and community organisations. Detailed feedback from a series of focus groups and telephone interviews has informed the findings. A web survey was used to supplement focus groups and interviews.

In this study, feedback was gathered from **73 stakeholders** in England, who were asked questions **about the relevance, usability, acceptability, and implementability of the recommendations on helping people of South Asian origin to stop using smokeless tobacco.**

The views contained in this report and the conclusions derived from them are entirely based on the evidence given by the stakeholders to whom we spoke.

GHK would like to thank all those who committed their valuable time in order to give their feedback during this study.

1.2 Background and scope

The Department of Health asked the CPHE at NICE to develop guidance on supporting South Asians to stop using smokeless tobacco. The draft guidance with six specific recommendations was developed by the Public Health Interventions Advisory Committee (PHIAC). The guidance is aimed at a wide range of stakeholders with public health as their remit, including service providers; commissioners; managers; health professionals; and voluntary and community groups, as well as schools and members of the community.

The draft recommendations support the policy goal to reduce health inequalities and are consistent with the Tobacco Control Plan for England (2011), which sets out the Government's expectation for stop smoking services to offer help to all tobacco users, including users of smokeless tobacco. The recommendations also support other related policy documents, including, the *Cancer Reform* Strategy (2007); *Healthy Lives, Healthy People: Our Strategy for Public Health in England* (2010a); *The NHS Outcomes Framework 2012/13* (2011a); and *The Operating Framework for the NHS in England 2012/13* (2011b).

The recommendations therefore respond to the health risks associated with smokeless tobacco use[2], and recognise South Asian groups as those who are most likely to use these products[3].

[2] The use of smokeless tobacco carries significant health risks. There is substantial evidence that use of smokeless tobacco is associated with serious health problems such as mouth and oral cancer, heart attack and stroke, and problems in pregnancy and following child birth. It can also lead to periodontal disease and the late diagnosis of dental problems. Smokeless tobacco can induce wrinkled changes in the oral mucosa ("snuff dipper's pouches") beneath the lip. These can lead to severe and permanent gum recession and bone loss, (London Health Observatory, 2011). Oral cancer is among the twenty most commonly diagnosed cancers in the UK, with 5,790 new cases diagnosed in 2008, (Cancer Research UK, 2011). Two thirds of these cases were in men. While oral cancer is not as common as cancers such as breast, lung, colorectum and prostate, the incidence rate is increasing significantly. Smokeless tobacco is one possible cause of oral cancer. However, risk varies according to the composition of smokeless tobacco used, and this in turn differs by cultural heritage.

[3] The most recent data on use of smokeless tobacco derives from the 2004 Health Survey for England, which included questions on the prevalence of chewing tobacco within the South Asian community in the UK. The survey involved those over 18 years of age of Indian, Pakistani or Bangladeshi descent and reported that overall there is much higher prevalence among those of Bangladeshi origin: 16% of women and 9% of men said that they chewed tobacco. Prevalence in the Bangladeshi community is heavily skewed by age and gender factors. Twenty nine per cent of women over 55 and 28% of women between 35 and 54 said that they chewed tobacco.

The draft recommendations also take account of the low levels of health risk awareness and the culture of using smokeless tobacco among users. Chewing tobacco is embedded in aspects of South Asian culture with symbolic implications at religious and cultural ceremonies[4]. Smokeless tobacco products are perhaps more socially acceptable in some parts of the South Asian community than smoking is, especially for women[5].

1.3 Structure of this report

The remainder of this report has sections on:

- **Methodology** (Section 2), describing the selection and characteristics of the sample, recruitment, and the analysis of data;
- **Feedback on the guidance as a whole** (section 3), analysing the evidence given by stakeholders that is relevant to the content and form of all the recommendations; and
- **Feedback on the individual recommendations** (sections 4 – 9), analysing responses to each individual recommendation.

This compares to only 9 per cent for 18 to 34 year olds. Age differentials are also present among Bangladeshi men with 8% of 18 to 34 year olds, 10% of 35-54 year olds and 14% of those over 55 chewing tobacco. Among Pakistani women, there is a higher prevalence among those over 55 year olds (6%), although there is no significant age variation among men. Both age and gender factors are less marked in the Indian community.

[4] ASH (2011), *Fact Sheets: Tobacco and Ethnic Minorities*, September 2011.

[5] Cooper, H., Arber, S., Jinn, J. & Smaje, C. (2000), *Ethnic Inequalities in Health and Smoking Behaviour*, NHS Health Development Agency.

2 Methodology

This section describes the aims and methodology used to carry out our fieldwork and analysis, including the fieldwork aims and objectives, recruitment strategies employed, and a description of the resulting sample. The data analysis techniques employed are also described in this section.

2.1 Aims and objectives of the fieldwork

The overall aim of the fieldwork was to capture stakeholder views on the recommendations in terms of how relevant, usable, acceptable, and implementable they thought they were. Seven specific questions were asked to meet this overall aim:

1. What are the views of commissioners, managers and practitioners, on the relevance and usefulness of the recommendations, to their current practice?
2. What factors could either help or hinder the effective implementation and delivery of the recommendations, as part of current practice?
3. What are the potential consequences of the recommendations for improving health and tackling health inequalities?
4. What is the potential impact of the recommendations on current policy, service provision or practice?
5. Which of the recommendations are both feasible and likely to make a difference to practice?
6. What would be the relative priority of each of the recommendations?
7. Do the potential relevance, usefulness, consequences, and impact of these recommendations differ between South Asian groups?

2.2 Sampling – approach and achieved sample

2.2.1 Selection of regions and cities

The guidance applies to a wide range of practitioners across England. To reflect this we selected six regions and cities within them that met the following criteria:

- **Regional spread.** In order to ensure the guidance is tested in a range of socioeconomic and healthcare provider contexts we proposed the six groups to take place in six regions;
- **Large South Asian populations.** We selected the regions – and the cities within them – which have the largest South Asian communities.[6] Within these we contacted PCTs serving areas with particularly high Bangladeshi populations, for example Tower Hamlets.
- **High levels of deprivation.** The cities we selected as venues for the workshops all score highly on the Index of Multiple Deprivation[7], as the evidence shows that those from lower socioeconomic groups are more likely to use smokeless tobacco.
- **Commissioning changes.** Ongoing reform of healthcare commissioning is likely to profoundly shape the provider landscape and the cessation services which are commissioned. Within our sample we included early implementer regions of GP

[6] Data on the resident population estimates by ethnic group were collected from ONS Neighbourhood Statistics 2009.

[7] The Index of Multiple Deprivation can be found at http://www.communities.gov.uk/publications/corporate/statistics/indices2010

commissioning, selected from the GP pathfinder consortia (for example South Birmingham Integrated Clinical Commissioning Consortium and the three Manchester consortia).

Our six groups were held in the following regions and cities:

- London (Tower Hamlets);
- West Midlands (Birmingham);
- North West (Manchester);
- Yorkshire (Bradford);
- East Midlands (Leicester); and
- East of England (Luton).

A total of **14 practitioners completed the electronic survey**.

2.2.2 Selection of individuals

In order to accurately reflect the diverse demographic for whom guidance is intended to improve service delivery, we aimed to consult with a wide range of practitioners: from those who play a planning and commissioning role through to individuals who provide cessation services as well as wider staff with public health in their remit. We aimed to have a third of each in the focus groups.

Overall we achieved a total sample of 73, which was made up of 47 focus group participants, 12 telephone interviews, and 14 survey respondents.

These respondents came from the following groups:

- 35 primary care and public health delivery staff (including smoking cessation advisors, dentists and pharmacists);
- 19 public health managers and commissioners (we include smoking cessation leads in this group);
- 12 from the voluntary and community sector; and
- 7 other/ no role given.

Participants came from a variety of settings, with community-based NHS staff predominant:

- Just under half of participants work primarily in a community setting and are employed by the NHS.
- Around a third are based in an NHS Trust public health department.
- The most common settings after these are:
  - Community settings, employed by a voluntary or faith organisation;
  - Primary care clinical setting, employed by the NHS;
  - Local Authority public/environmental health department.

Across these settings, respondents had a range of roles. However, a majority work in providing tobacco cessation services:

- More than half of the participants, both in the focus groups and electronic survey had a role providing services specific to preventing and stopping tobacco use;
- About a quarter were commissioners, and of this group more than half self-identified as commissioners of tobacco cessation services;
- Only two participants identified themselves as senior managers in public health. Where participants did hold management positions, the majority of these were managers of tobacco cessation services; and
- A fifth of participants self-identified as having outreach and community liaison activities within their remit.

Most practitioners regularly work with or co-ordinate activities for people from South Asian backgrounds.

- Most practitioners reported that they regularly worked with a range of South Asian communities, with no particular subgroup predominating; and
- However, of those practitioners who did work with particular groups only, the Bangladeshi community was most often cited.

We found that **practitioners with a specific remit for tobacco cessation were most likely to respond to the consultation**. Despite this, we engaged with a diverse range of practitioners, including:

- Public health managers;
- GPs;
- Dentists;
- Pharmacists;
- Trading standards;
- Local authority environmental health staff;
- Patient representatives;
- Religious leaders; and
- Community activists.

2.3 Recruitment methods

Recruitment was conducted using a purposive sampling process, designed to recruit a diverse group of participants.

The recruitment process was carried out as follows:

- A letter of authority, explaining the field testing and its purpose, was sent to the smokeless tobacco specialist or stop smoking manager in each of the target organisations. We then worked with them to identify a suitable date and venue for the focus groups.
- Suitable participants in each organisation were identified in consultation with the lead contact using a recruitment proforma highlighting the key groups that NICE wished to consult with. Where participants did not find it convenient to attend a focus group or did not attend, they were invited to participate in a telephone interview or the electronic survey.
- **For focus group and telephone interview participants,** Informed consent was obtained from each participant once they had agreed to take part (see Annex 6), as well as a recruitment proforma collecting information on their job role, (see Annex 4). Shortly before the field testing took place, the draft guidance was sent in full to all participants, along with a short pre-reading task designed to help structure their thoughts prior to attending.
- Participants who did not return consent forms were given the opportunity to complete them at the focus group/telephone interview. At this point, all participants were asked to complete a sign-in sheet to collect information about their job roles and organisation, and an ethnicity/disability status monitoring form (see Annex 5).
- **In the case of potential survey participants that showed an interest**, email contact details were kept on file until the opening of the electronic survey in March. At this point, potential participants were emailed a link to the survey; they had approximately three weeks to respond. The survey included a consent letter, recruitment pro-forma and

ethnicity/disability status monitoring form, identical to those given to focus group and telephone interview participants.

2.4 Data gathering and analysis

Each focus group discussion was attended by two researchers: one took the lead facilitator role and the other was responsible for scribing and audio-recording the discussion. The scribe was responsible for writing up the discussion soon after the event. Telephone interviews were audio-recorded and written up soon after completion. Write ups for focus groups and interviews were structured by the individual recommendations, supported by stakeholder quotes, and themed according to the fieldwork aim and objectives, (see Section 2.1).

Once all the focus groups and interviews were completed, analysis took place using a content analysis approach. Using the fieldwork's key aim and objectives, the researchers identified core themes emerging from the data, defining concepts, providing explanations and finding associations and key differences between the views of different groups of participants. These were inserted into analytic templates (see Annex 7), for an examination of summarised themes prior to reporting. Regular briefing and debriefing sessions took place throughout the fieldwork process, to agree themes and ensure that analysis was carried out in a robust manner.

Qualitative data submitted via the online survey was analysed in the same way as described above for the focus groups and telephone interviews. Survey quantitative data (e.g. rating the relevance of a recommendation on a five-point scale) was used in conjunction with qualitative content to lend further support to a theme or provide a counterpoint. Because of the small sample size, we are not reporting this data as precise percentages of survey respondents holding a certain view.

3 Feedback on the guidance as a whole

This section examines participants' responses to the NICE recommendations on *supporting people of South Asian origin to stop using smokeless tobacco* as a whole. Good practice examples are included, and the implications for NICE are discussed in relation to feedback from stakeholders on the guidance as a whole.

Subsequent sections will then examine the responses to each of the recommendations individually. Each of the draft recommendations is summarised at the start of Sections 4-9.

3.1 The guidance was welcomed: stakeholders thought this was an important step towards raising the profile of smokeless tobacco use

Stakeholders were unanimous in welcoming the guidance as a positive directive from NICE. There were many discussions about the nature of smokeless tobacco use as a problem, the cultural context of the behaviour, and of the need to raise awareness amongst both the general community, and also among health service commissioners, managers and service providers.

In discussing the need to raise greater awareness of the behaviour, stakeholders often made comparisons to the progress of smoking in public health. Reflections included that smokeless tobacco use is not as visible a behaviour as is smoking; that people are less aware of the health risks; and that smoking as a public health issue has benefited greatly from legislation which cannot be easily applied to smokeless tobacco use - there is no passive health risk associated with the smokeless variety of tobacco.

Lack of general awareness of health risks was linked to the cultural context of the behaviour, where its intrinsic social use has functioned to normalise its use – for example the custom of offering smokeless tobacco to visitors was mentioned, as were the practices of enjoying these products after a meal as digestive aids. In one group this discussion developed further to include a need to address smokeless tobacco use in order to reduce health inequalities: for equitable access to tobacco cessation services, more information should be provided to South Asians on the smokeless variety so that they can make the same informed choices as smokers can.

3.1.1 Profile raising requires continued education and communication of a strong evidence-based rationale for commissioning these services

The fieldwork revealed some substantial knowledge gaps among some stakeholders who should have knowledge and understanding of smokeless tobacco use. Many of the discussions tended to include a rehearsal of different products, and stakeholders showed different levels of confidence in discussing these. Although it was acknowledged that the guidance contained lists of products, it was felt that this could be expanded on. More education was requested in the following ways:

- Providing a fuller list of products in the guidance document;
- Providing guidance on pronunciation of the products;
- Providing pictures of products as a visual aid both within the document but also in a form that could be shared with potential users;
- Distinguishing in the product list the different products which are used by different communities; and
- Making information on products accessible on a dedicated website.

Similarly educational needs were discussed in relation to the rationale for commissioning smokeless tobacco services. Although it was acknowledged that the guidance documents research evidence, commissioners still felt that there is some way to go. Their comments included that they needed a fuller evidence base to justify investing in smokeless tobacco cessation. In particular the efficacy of interventions and potential cost savings were of interest to these stakeholders. Again comparisons were made to smoking, and the need for

smokeless tobacco use to 'catch up'. Nevertheless it was felt that this guidance was important for paving the way for profile-raising, and that it might at least allow services to be piloted:

"(The guidance*) should be a useful tool for commissioners who don't really know what to do with this at the moment."*

3.2 The potential impact of the guidance is determined by funding resource

Funding was an often mentioned barrier for implementing the recommendations. Stakeholders commented that increasing provision for smokeless tobacco cessation requires additional resource which is difficult within the context of continued budget cuts. This was particularly a barrier in areas which were not currently providing a service for smokeless tobacco use. Stakeholders feared that even to include this within current Stop Smoking services would require additional funding for Nicotine Replacement Therapy (NRT) and cotenine testing kits.

Funding as a barrier was also discussed in relation to incentives for primary care health professionals to act upon this guidance. Stakeholders commented on the difficulty of impacting on practice in the absence of clear incentives for health professionals such as GPs. Some stakeholders commented on the non-mandatory nature of the guidance, and the limits on impact that this creates:

"Until smokeless tobacco becomes more recognised as a problem, it won't be included in any Department of Health targets."

3.3 Stakeholders thought the guidance was clear and understandable in general, but some changes were recommended in terminology and target audiences

Most stakeholders found the guidance to be clear and understandable. The recommendations were described in general as useful in setting out what is expected of all the key players: commissioners, funders, health practitioners, educators and specialist services working in the community in cessation services. However, some stakeholders thought that some of the target audience groups were in need of better clarification. In addition, it was felt that target audiences for specific recommendations could be expanded in some cases.

Some commented however that although the individual recommendations were clear, the grouping of these was not – repetition and overlap was a problem for some, although others acknowledged that this was necessary. Stakeholders in some of the groups also suggested that the recommendations needed re-ordering for better clarity – for example having a consistent 'story' through the recommendations by positioning those which refer to commissioning first, followed by training, and then those that refer to services nearer the end.

The terminology was questioned for terms such as 'targeting' South Asians, and 'myths' about smokeless tobacco. Voluntary and Community Sector (VCS) representatives commented that the terminology may be a barrier for their sector, and suggested that this could be simplified. These representatives also thought that the recommendations were lengthy and that a one-page summary might be useful. Stakeholders from the VCS were hugely positive about this guidance, and welcomed being involved in raising awareness for smokeless tobacco cessation. However many found it difficult to comment on the detail of individual recommendations.

3.4 Stakeholders noted some gaps in the guidance

A key gap was noted in reference to new structures and organisations which will become responsible for public health post-2013. Stakeholders were surprised that there is no specific mention of these in the target audiences identified. In particular, Clinical Commissioning

Groups (CCGs), and Health and Well-being Boards were noted to be instrumental in the future of smokeless tobacco cessation services.

Another gap identified was that the guidance could better link with policy and other relevant guidance – such as that on smoking - throughout the recommendations. Although the references to related guidance in the document were acknowledged, it was thought that these could have been better integrated within specific recommendations.

Some stakeholders were also concerned that the recommendations do not include any guidance on the use of NRT for smokeless tobacco cessation services. They reflected that this may be because of a lack of strong evidence on efficacy of NRT with this group, but nevertheless thought that some practical guidance on its use would still have been useful.

These issues and specific examples will be picked up through the remainder of the report, when discussing the individual recommendations.

The fieldwork identified geographical variation and some examples of good practice

The fieldwork revealed a high degree of variation in how different areas are responding to South Asians who use smokeless tobacco products. In some areas provision is at present low, and there are no specific services or incentives to commission these:

> *"I think we need to go back and look at this as a service and think about how we deliver services for smokeless tobacco, and actually as a service we don't. So that's service development and improvement."*

Other areas are more developed in their responses to smokeless tobacco. The group discussions in Leicester and Tower Hamlets, for example, included views that the recommendations were more of a reflection of their existing practice. In Tower Hamlets, smokeless tobacco services in the community have been developed over the last ten years, and other parts of London are beginning to be aware of the need. In the Manchester group, the example of a recent project in Tameside was discussed, where the aim had been to understand prevalence of smokeless tobacco. The project consisted of community engagement activities, training volunteers, and the development of a bi-lingual set of resources.

3.5 Implications for NICE

Stakeholder response to the guidance has shown that **it is needed** in order to both raise awareness and improve provision for South Asian users of smokeless tobacco. The fieldwork has itself contributed to raising awareness; as well as gauging people's views, it has engaged them in reflective discussions about smokeless tobacco use services in their local areas.

Smokeless tobacco use is still a relatively 'young' concern for public health: it is less understood as a behaviour than smoking is, and there is still a need for further research into the efficacy of service models. For these reasons **knowledge and understanding is still low** among those stakeholders for whom this is part of their job. NICE needs to be aware of this and to recognise that knowledge of products will need to be disseminated and kept updated in support of this guidance.

Because of the comparatively low awareness of smokeless tobacco use, **dissemination of the guidance needs to be wide.** Stakeholders discussed how it is important for it to be sent to frontline workforces, as well as to managers and commissioners. Other ideas for dissemination included publicity in supermarkets and community settings, and holding a conference event to raise awareness. An event such as this could be used to launch the new guidance.

Funding constraints are also a reality for stakeholders and present a significant barrier for implementing the guidance. In the absence of national funding the implementation of this guidance is much more **vulnerable to variations between local areas**. In one group there was a discussion that the guidance could potentially accentuate inequalities – if neighbouring areas vary in their responses to the guidance and resultant provision of services for smokeless tobacco use. Integrating within the recommendations references to national policy (where there are statutory duties) and other relevant guidance may be a **useful lever for maximising its impact.**

Ultimately the implementation of these recommendations will depend on what local areas are already doing to tackle smokeless tobacco use among South Asians. The fieldwork has shown considerable geographical variation, indicating that **some areas will have longer journeys to travel** in responding to these recommendations.

4 Recommendation 1: Assessing local need

Recommendation summary

This recommendation is intended for directors of public health, managers of tobacco cessation and prevention services, and public health commissioners and specialists responsible for local tobacco cessation activities.

The recommendation focuses on achieving a greater understanding of smokeless tobacco use, and the communities within which this is most prevalent. In this recommendation there is an emphasis on working in partnership to routinely collect data which will help better understand smokeless tobacco use by South Asians. Data to be collected includes that relating to prevalence, incidence, types of products used, the demographics of users, and the associated health problems resulting from use. In addition data on user perceptions of health risks associated with these products is recommended.

The recommendation also covers establishing an understanding of service related indicators, such as the number of South Asians who have recently sought help, and the extent of smokeless tobacco cessation service promotion and provision.

General feedback from focus groups and interviews on this recommendation was that the wording was appropriate, and that it was clearly understood. Survey findings supported this, with all respondents agreeing that they understood the recommendation either completely or mostly.

In reference to the links between recommendations, it was suggested that this recommendation fits well with the third one, and that recommendation 3 would be better positioned as recommendation 2, so that it continues on from this first recommendation.

Focus group feedback for recommendation 1 included that it is necessary, and that potential impact is high if it is successfully implemented. Survey feedback on usefulness and potential to improve practice was more mixed, with stronger agreement for the usefulness of the recommendation, compared to its potential to improve practice.

Many barriers to achieving this impact were discussed. Details of this feedback are given in the remainder of this Section, and key changes are summarised at the end of the Section.

4.1 This recommendation was seen as a necessity with potential for high impact

This recommendation was welcomed by stakeholders as a necessary first step. Stakeholders realised the need to know more about the issues and prevalence before action to address these could be taken. The two quotes below are taken from comments made by tobacco specialists in different groups:

> *"Research to understand local needs has to be the starting point."*
>
> *"It's difficult for us to work with other groups to show them that there is work to be done if we can't be clear on why it is needed."*

The need for this recommendation was equally acknowledged in areas where some considerable work had already been done in smokeless tobacco cessation provision. In one such group there were comments about how the quality of information currently held could be improved. Although there was some information on types of products and users this was deemed to be insufficient, inaccurate, out of date, and not widely shared. The data held was not thought to be locally relevant as planners have had to make use of what data is available – in this example the now very dated 1994 Health and Lifestyle Survey.

The problems with the quality of information held are also a function of time and capacity, which many services are struggling with. One senior public health manager commented that this is why they need a national steer on data collection, similar to that provided for smoking cessation.

Stakeholders felt that if this recommendation were successfully implemented then the potential for impact on practice is high. There is an opportunity to increase knowledge and

understanding, as well as to increase referral rates and brief intervention practice by GPs and dentists. There were however many barriers to successful implementation identified, as well as some suggestions made for modifying the draft recommendations, which are detailed below.

4.2 An accurate reflection of the 'need' will be difficult to achieve

Stakeholders reflected on the difficulty in achieving an accurate reflection of prevalence rates for smokeless tobacco use. Discussions on this centred around under-reporting and the reasons for this, which would impact on the accuracy of data recorded: *"Even if people chew tobacco, they don't freely admit."* Reasons discussed for under-reporting also included the difficulty of accessing the groups where this behaviour is particularly prevalent – for example in South Asian (particularly Bangladeshi) women.

Stakeholders commented that the use of tobacco products among older South Asian women is not known outside of the community. In addition there were views about low access of this group to health professionals. However some dissent from this view was also indicated – dentists and community pharmacists felt that their services were more accessible to this group than others.

4.3 A key barrier for implementing this recommendation is that the profile of smokeless tobacco cessation is still low: there are implications for raising awareness, knowledge, and funding

A recurrent barrier to implementation was the need to raise the profile of smokeless tobacco use. Of relevance to this recommendation was the view that data will not be realistically collected by practitioners until there is more awareness and a stronger evidence base communicated to raise the profile of this as a serious public health concern. Awareness raising was therefore thought to be a good start to collecting this data. Stakeholders stated that *"people need to be educated"* in the community as well as in the relevant health and community sectors.

Smokeless tobacco use was commonly referred to as the *"poor relation"* of smoking in terms of the knowledge gaps that still exist. Particular issues in relation to this recommendation included the list of products which the audience is referred to. There was some concern about the accuracy of the list and the need to regularly update it as changes to products occur. One suggestion was the need for local identification; there are more than 132 products and these might be better grouped by ethnicity. It was mentioned that different South Asian ethnic groups - and indeed different age groups and genders within these – will more commonly use some of the products than others.

The battle to raise the profile of smokeless tobacco was discussed within the context of current financial challenges, where raising awareness and indeed improving service provision and access will be made more difficult by continued budget cuts, organisational change, and job losses. Stakeholders reflected that these challenges will mean that these services could be low on the list of priorities – which will undoubtedly affect the impact of the guidance:

> *"Until smokeless tobacco becomes more recognised as a problem, it won't be included in any Department of Health targets."*

The resource implications will be greater for those who are not well established in this work already. Balancing cost against the relatively low profile led some commissioners to state that this recommendation did not carry enough 'weight' for them to implement it. Concerns about funding for implementing the recommendation were not contained within public health commissioning. Primary care and VCS representatives also voiced similar concerns. The lack of incentives for primary care professionals were discussed and compared to smoking, where recording status is a requirement for GPs through mechanisms such as the Quality Outcomes Framework (QoF).

"GPs don't do anything without incentives and neither will the VCS. People think we can live on good will."

4.3.1 Understanding the cultural context is a key type of knowledge required

Some stakeholders reflected on training requirements for carrying out research which effectively assesses local need. They stated that a good knowledge of the cultural context is important before a needs assessment can be carried out: staff will need to be trained so that they know the right questions to ask about the right products.

In addition to this, stakeholders discussed how gaining entry to the relevant communities in order to develop understanding might be difficult. The health risk message and raising awareness among communities was seen as integral to the needs assessment. Some stakeholders discussed the challenge of communicating this message to users:

"Many don't have that level of understanding because of the way it is rooted in social activities amongst people who are not aware of the health impacts."

"Some of them even think that it is healthy – it is promoted back home that it has benefits."

However, one stakeholder thought that once the message had been communicated, powerful effects can be observed. This stakeholder commented that sometimes raising awareness is enough to result in cessation; a successful local project with Bangladeshis in Manchester was described, where once awareness had been raised, it was found that users required little support to quit.

4.4 Target audiences are appropriate, but should be broadened to include new structures and to avoid a 'top-down' approach

Stakeholders felt that the recommendation is indeed relevant to all the target audiences listed for this recommendation. However key audiences forming part of the new structures in the NHS reforms were also noted as missing from this list. Organisational change is particularly relevant to target audiences and may in its own right be a barrier to implementation of the guidance. In particular, it was noted that this recommendation was relevant to emerging public health bodies (local authorities and the Department of Health), and to CCGs who will control 95% of the NSH budget. Inclusion of them in these recommendations will be vital to ensuring continuity of provision post 2013.

In addition, some stakeholders reflected that an avoidance of a 'top-down' approach requires a wider inclusion of target groups. There were comments about the need to include *"people on the ground"*, such as primary care professionals and staff in schools and the VCS. One health professional stated *"I think the most important people to speak to would be us, the clinician, to give us advice on how to speak to people because we see the patients first hand."*

It was felt that this recommendation was of particular relevance to primary care practitioners, who would be required to collect data to inform the needs assessment. Assessing need is reliant on primary care professionals collecting prevalence data, and current practice indicates that they do not systematically ask about smokeless tobacco use. A broad definition of primary health care professionals was used by stakeholders, for example in dentistry this includes domiciliary practitioners who could aid data collection as part of home screening – which is particularly used by older South Asian women.

4.5 The recommendation is lacking in detail – this is a barrier for the successful implementation of it

Stakeholders generally wanted more detail about the practicalities of implementing this recommendation. It was thought that the recommendation needed to be more specific to be implemented. Further detail was requested in terms of specific roles for particular professional groups; for example, who are the groups that should be responsible for collecting the data, and how should this be collected? Questions were raised about whether

particular professional groups should be responsible for this – GPs, dentists and midwives were discussed, as were lifestyle surveys. In general local teams reflected that they would find it very difficult to collect data without proper mechanisms for doing so – which in turn would require additional resource.

4.5.1 More guidance on standardising data and data sharing protocols would be useful

The need for standardised data was highlighted as a gap in this recommendation, with stakeholders stating that data collected needs to be comparable across areas. In one group there was discussion about how good practice can be taken from within the Stop Smoking service, where a national client record is used to ensure that there is consistent data collected across the country.

The need for consistent data recording is also reliant on effective data sharing across organisations, and this was mentioned as a potential barrier for implementation. Some stakeholders talked about how sharing information locally between public health professionals and cessation services can be difficult. Others reflected that different primary care practices collect information in different ways, and this presents a challenge for dataset consistency.

Key changes to this recommendation

- Broaden the list of target audiences, to include emerging public health bodies, CCGs, primary health care professionals, schools, and the VCS. Include specific roles for each to maximise likelihood of implementation.
- Provide more detailed guidance on data collection mechanisms, on the importance of standardising data, and on data sharing protocols.

5 Recommendation 2: Working with local South Asian communities in areas of identified need

Recommendation summary

This recommendation is directed at a wide range of stakeholders, including directors of public health; managers of tobacco cessation or prevention services; and others with a remit for managing tobacco cessation services, or with responsibility for the health and well being of South Asian communities. In addition schools and local voluntary and community groups with a relevant remit are also included in the audience for this recommendation.

The recommendation is centred on partnership working, developing relationships, and gaining trust between organisations in order to plan, design and coordinate cessation services for smokeless tobacco. The recommendation includes raising awareness (in schools), addressing misconceptions (of health benefits), and ensuring accessibility of services by using community venues.

In addition there is guidance on marketing services so that material is accessible - by using the right product names, by addressing language issues, and by targeting women. This guidance also includes providing education on addiction and health risks, and avoiding stigmatisation of users in their own and in general communities.

In general this recommendation was considered to be necessary in communicating the health message of smokeless tobacco use. Most stakeholders thought the recommendation was easy to understand. Survey results supported this with all respondents stating that the recommendation was either completely or mostly understood.

A few stakeholders suggested that the recommendation was a little too *"wordy".* One comment related to the use of consistent terminology. Some stakeholders thought that there could be more clarification on the use of 'with a remit for tobacco cessation'. Some stakeholders also thought that the elements of service delivery in this recommendation overlap considerably with recommendation 6 where they are better placed.

Feedback for recommendation 2 related to the roles of target audiences, and to the focus on community involvement. Culture was identified as a key challenge for implementing this recommendation. Details of this feedback are given in the remainder of this Section, and key changes are summarised at the end of the Section.

5.1 The groups identified to take action are appropriate but more detail may be required to differentiate roles

The wide scope of the target audience was appreciated by stakeholders, who thought that all those listed had a role in implementing this recommendation. However, it was also thought that this long list led to confusion about the different roles of each of these target audiences. Clearer guidance was requested in relation to the differential roles; it was thought that a lack of clarity on roles would lead to disengagement with the recommendation and the guidance as a whole.

In particular the specific role of schools was questioned. Comments about the role of schools included that they had an important role to play in raising awareness of young people who may not engage with health professionals. One discussion centred on school nurses, and how they are better placed than teachers to dedicate time to receiving training in this.

Some representatives from the VCS were concerned that they would be expected to be responsible for planning, which they said was not within their remit. This was supported by an example of practice cited: in one area the Stop Smoking Service had previously partnered with the VCS for delivering services. This had not been successful because of a lack of resource and capacity in the VCS. It was also thought that delivery was better from statutory health specialists, as these services were thought to be more credible by users.

Solutions were suggested by stakeholders in the form of amending the recommendation(s) to better differentiate between commissioner/strategic and provider/operational functions.

There was general support for a pathway approach, with the VCS role being to champion awareness, advocacy for users, and signposting them to the statutory sector which would refer through the rest of the 'pathway' of services.

Some community pharmacists thought that they should be included in the target audience for this recommendation. These stakeholders stated that they had an important role to play, as they are involved in community outreach, and also have relationships with the community which other health professionals may not necessarily have.

5.2 Community involvement

The principle of community involvement in this recommendation was welcomed by all stakeholders. Some suggested that this principle could be extended further so that the guidance is '*driven by rather than working with South Asian communities'*.

The VCS was seen as an important 'way in' to working with local communities, as *"it is at the local community level that you will get this information, and that* (you will) *have access to the people you need to help."* These organisations are closer to communities than health professionals. However, one representative cautioned against the assumption that there is sufficient knowledge in the VCS to meaningfully comment on smokeless tobacco use, and suggested that it was also important to consult with users.

For some stakeholders this recommendation was conceptualised within 'community development' – which was an important part of smokeless tobacco cessation services already being delivered. These stakeholders talked about how they have worked with taxi drivers, barber shops, community centres, and religious establishments to involve the community in services.

Religion may be an important lever for raising awareness. In Bradford there was an example of good practice cited, where advisers had visited mosques to encourage engagement. Religious leaders who participated in the fieldwork welcomed being involved and offered the use of religious buildings for awareness raising events. They also discussed how their role in raising awareness of health risks is fundamental to their religious ethos. One local imam commented *"if it is proven scientifically that these things will shorten your life, then it becomes against their religion because killing yourself, even if you kill yourself one day early, is against any of their religions."*

Stakeholders experienced in deliver**i**ng smokeless tobacco cessation services shared their views on how one to one sessions in the community had been more effective than GP visits. It was suggested that the best approach was to educate the community rather than to explicitly advise against chewing – *"it is best to use a 'did you know' approach rather than a 'stop chewing' one."* Stakeholders suggested that education was best delivered by *"people from within the community, rather than someone coming in lecturing because the trust thing is there, definitely, if it is someone from within their own community it will be easier to understand the information."*

5.3 Raising awareness will take time, and culture will be a key challenge

Raising awareness was considered by stakeholders as the key to the success of this recommendation. It was noted that cultural sensitivity would be important when raising awareness, so that South Asians are not stigmatised. Discussions took place on how community groups may be better placed to build trust and provide basic education on smokeless tobacco. Many stakeholders thought that reaching people to raise awareness through the health profession will not be effective for two reasons:

1) People are unwilling to report to dentists and GPs for fear of stigma, and a basic unawareness of the health risks; and
2) Health professionals are reluctant to probe the use of smokeless tobacco due to time and lack of training. One dentist described how although she had received training when qualifying on the health risks for smokeless tobacco use, she had never received any training on **how** to ask patients about its use.

It will take time to raise awareness and for there to be wider knowledge on the health risks of smokeless tobacco use. Stakeholders noted again the comparisons to smoking, and described smokeless tobacco use as *"years behind"*. The cultural context of the behaviour was also discussed as a reason why it would take time to communicate the health messages. It was noted that smokeless tobacco use is embedded in culture, and that it has been practised for years for social and 'health' functions. It was suggested that overcoming the cultural challenges could be achieved by working through religious organisations, as *"religion often overpowers culture."*

Key changes to this recommendation

- Define the roles of different stakeholders more clearly, and consider a 'pathways' approach to raising awareness, signposting, referring and delivering services.
- Maintain community involvement principle, but consider expanding this to make more specific references on how to reach different parts of the community. Faith communities as a lever for raising awareness should be made more explicit in the recommendation.

6 Recommendation 3: Planning and providing services in areas of identified need

Recommendation summary

This recommendation is intended for directors of public health, managers of tobacco cessation and prevention services, and public health commissioners and specialists responsible for local tobacco cessation services.

The recommendation is closely linked with recommendation 1, with the suggestion that the local needs assessment is used to commission a range of smokeless tobacco cessation services. Recommended services include those within existing smoking cessation provision and those which are separately branded services.

It is advised that these services are coordinated with, or linked to national stop smoking services, and that they form part of a local tobacco control strategy. In addition it is advised that these services form part of a wider range of services addressing broader health needs of South Asians. A partnership approach is encouraged with services being planned in consultation with voluntary and community organisations, user groups and local South Asian communities.

Lastly, this recommendation includes reference to monitoring and evaluation with the reporting of a number of outcomes including the number of quit attempts; percentages of successful quits at 4 weeks, 6 months, and 12 months; percentage with adverse effects; and any increase in tobacco smoking once people have quit the smokeless variety.

This recommendation was not easily understood by stakeholders. There was confusion about who it was intended for, whether it was a recommendation about planning or providing services, and what service structures were being recommended. Survey responses showed a slight dissent from this, with many responses confirming a complete or 'fairly good' understanding of the recommendation. However, in comparison to the other recommendations, survey responses for this recommendation indicated the lowest levels of understanding.

There was also considerable discussion on how this recommendation overlapped with others, and what the distinction was between it and others. It was suggested that this recommendation should sit after recommendation 1, as these two fitted together well. Yet others were unclear how this recommendation differed from recommendation 2. There were also comments that this recommendation repeated material in recommendation 6.

Details of this feedback are given in the remainder of this Section, and key changes are summarised at the end of the Section.

6.1 Stakeholders were confused about target audiences – it was unclear whether this recommendation is for planners or providers

Many stakeholders questioned the purpose of this recommendation, in particular in terms of who it is directed at. While the target audiences listed indicate it is a recommendation for managers and commissioners the title and some of the content includes reference to *providing* services. It was noted that planning and providing services are functions carried out by different job roles, and that the recommendations need to be specific to either commissioners or providers.

Some stakeholders also thought that more clarification was needed about the generic descriptive 'managers of tobacco cessation or prevention services'. Reference to the Joint Strategic Needs Assessment (JSNA) was noted as a gap, and it was suggested that the Health and Wellbeing boards are included in the target audience, since these will govern future services.

6.2 The structure of the service is unclear - clarification is needed about whether this recommends a new service is established

This recommendation invoked a plea for further clarification on the recommended service structure. In particular, stakeholders questioned whether this was recommending the establishment of a separate service, whether these *"new"* services would be part of national teams, and whose responsibility it was to deliver these services. Others were unsure if the recommendation relates to a service or to training, and there were comments about a need to cross-reference brief advice and specialist services in this recommendation.

There was considerable debate about whether services for smokeless tobacco should be *"separately branded"* services, and on whether they should be delivered through the existing Stop Smoking services. Some stakeholders thought that separately branded services would be good for targeting 'hard to reach' groups in need of support. Others felt that separately branded services ran the risk of stigmatising South Asians and causing tensions between ethnic groups in the community. There were also reflections that separately branded services could result in confusion for people when navigating services.

The general consensus amongst stakeholders was that services should be part of mainstream tobacco cessation services, but that they should be tailored to be made appropriate for the relevant communities:

> *"The service has to be there but it must be appropriate to need."*

In one group the discussion culminated in agreement that smoking and smokeless tobacco services should be strategically part of the same service since the same professional teams will deliver both services, but that the smokeless tobacco services need to be marketed differently (e.g. in relevant community venues). This was also supported by a stakeholder who took part in a telephone interview: *"I don't see a problem with it being all together, as long as it is well organised, but I think the name of it should change, when it is advertised you should make a point of it saying it is targeted as chewing pan or chewing tobacco."*

One stakeholder commented that smokeless tobacco use is a different 'problem' to smoking as it is not seen by users as an addiction; the general level of awareness compared to smoking also requires a different approach.

Some stakeholders also suggested that the recommendation could make reference to modelling services on good practice already taking place in this area. In Tower Hamlets there was agreement that services should be integrated. Stakeholders here commented that it has taken 10 years of developing these services to raise awareness and integrate this work into mainstream health improvement work.

6.3 A number of amendments were suggested to the recommendation for recording outcomes

General feedback about the recommended outcomes was that they were appropriate and easy to report. Resource implications were discussed however, for example funding for appropriate testing kits, which were described as more costly than those used for validation smoking quits. A number of suggested amendments to the listed outcomes were raised by stakeholders:

- More guidance is required on who should be reporting outcomes – dentists felt that this is not part of their role and that they would refer to specialists who should record data. Stop Smoking specialists felt that these outcomes were appropriate and easy to report for them.
- The quit attempt targets should be amended. Quits are more difficult to achieve with smokeless tobacco as there are higher relapse rates because of the higher nicotine levels in some products compared to smoking tobacco products. Follow-up requirements are therefore more intensive, and measuring quits at all three time-points will be difficult. The relevance of recording targets was questioned; these used to be mandated targets for smoking but are being phased out in favour of recording prevalence rates.

- The term 'adverse effects' should either be taken out or defined more clearly.
- The listed outcomes should be categorised by 'outputs' and 'outcomes'.
- There should be reference to including these outcomes in provider contracts and service agreements.

6.4 Designing targeted services requires cultural sensitivity

This recommendation's reference to targeted services again drew a discussion on the need for cultural sensitivity. Some stakeholders commented on the need for subtlety when targeting, in order to ensure that South Asians are not stigmatised. Other stakeholders suggested that South Asian communities are less concerned about stigma and are open to hearing a clear message about health risks. One service provider described how they had anticipated cultural barriers of trust but had found that these were easily broken down once they engaged with communities.

Discussions also ensued in relation to defining cultural sensitivity – this is not necessarily about understanding smokeless tobacco use and any associated stigma for users, but more about building relationships and understanding the heterogeneity of 'South Asian' groups. This heterogeneity refers also to different groups within ethnic groups, and understanding what is important for building relationships with people from these different groups. For example the language used to address an older Bangladeshi woman (e.g. 'auntie') compared to how one should engage with younger people.

Understanding the broader cultural context was also discussed in terms of appreciating the need for accessible and flexible services as *"these people don't usually venture very far, they are more likely to attend a talk or something like that if this was on their doorstep."* Ultimately the key ingredient for designing targeted services that are culturally sensitive was regarded as investing in learning more about the target communities; *"unless you are there in the community you cannot really decide where the money should go and what people's needs are."*

Key changes to this recommendation

- Clarify target audiences, making distinctions between commissioners and providers clearer. Consider focussing this recommendation on planning and commissioning and amend title to this effect. Wherever possible, refer to job roles when listing target audiences rather than to generic descriptions.
- Address overlap and repetition between recommendations and be clearer about the distinctions between these. Consider re-ordering this recommendation for a more coherent narrative.
- Provide more specific guidance on the nature of the recommended services, particularly in relation to responsibility and structure. Consider how good practice can be used to share learning.
- Redefine outcomes so that they are aligned to those for similar services and be clearer about which job roles are best positioned to record outcomes.

7 Recommendation 4: Providing brief advice and referral: dentists, GPs, pharmacists and other health professionals

Recommendation summary

This recommendation centres on providing brief advice and referral, and so is directed to health professionals, including dentists, GPs, and other relevant health practitioners such as dental nurses, dental hygienists, community pharmacists, midwives and health visitors.

The recommendation aims to improve the practice of health professionals asking about smokeless tobacco use, recording information related to this, and referring on to specialist services where appropriate.

General feedback for this recommendation was that it is very useful and relevant. Survey responses supported this, with all respondents agreeing that they understood the recommendation either completely or mostly. Some of the survey respondents also said that the recommendation was either very useful or somewhat useful.

Stakeholders had a good understanding of 'brief intervention', and some thought that this recommendation supported recommendation 1 of assessing need. Some comments also reflected that this recommendation was better positioned after recommendation 5 – as training is a precursor to delivering brief advice and referral.

Identified challenges for implementation included that the mechanisms for recording brief advice and referral are not in place, and that health professionals do not always have the knowledge to feel able to intervene.

Details of the feedback are given in the remainder of this Section, and key changes are summarised at the end of the Section.

7.1 The recommendation was welcomed by health professionals, but the target audiences require some revisions to reflect services

This recommendation was welcomed by health professionals who thought that asking about smokeless tobacco use was relevant to their practice. It was noted that in practice this behaviour was probably more likely to be asked by those health professionals who work in areas where there were large numbers of people of South Asian origin; *"if there is a high South Asian population it might be on their radar."* Health professionals thought that this could be easily incorporated into a list of standard health questions they already ask – such as drinking and smoking habits.

A key observation of target audiences was that professionals such as GPs and dentists *"should not be separated from the teams that work in their practices"*, and instead should be identified as a group of practitioners, such as 'primary care teams' and 'dental practice teams'. It was also noted that this recommendation is relevant to secondary care teams, since they are likely to see the effects of smokeless tobacco use.

7.2 Stakeholders had a good understanding of brief intervention and discussed definitions of this service

Stakeholders were able to discuss in detail the nature of brief intervention, and thought that the recommendation did not fully capture this. This was mainly in terms of references in the recommendation to supporting quits and evaluating intervention outcomes. A brief intervention was described using the terms *"advice and act"*, which can be broken down into four steps:

1) Make an assessment of whether patient is using smokeless tobacco products;

2) Raise awareness of health risks associated with smokeless tobacco use;

3) Give brief advice for cessation of smokeless tobacco use; and

4) Refer to specialist services.

Stakeholders discussed how the focus of brief intervention by its very nature is on the delivery of advice, rather than on supporting a quit or checking whether the intervention has 'worked'. It was thought that at this stage the intervention is weighted towards raising awareness and referring on, and that evaluating whether the intervention has 'worked' is not an appropriate intermediary step; *"brief advice is you give them advice and make the notes, and get the person to go to the service."* This is particularly important when considering the length of a standard consultation and the extra time that will be taken in identifying tobacco use from the various products; this is not the case for smoking which is a simple yes/no question.

7.3 This recommendation supports integrating smokeless tobacco cessation services within mainstream services for smoking

Stakeholders recognised this recommendation as a description of brief intervention for smoking cessation services, and so were able to see how services for smokeless tobacco cessation could be easily integrated into existing smoking services. Some comments included that Stop Smoking services are already training practitioners in brief intervention for smoking and that this could be extended to include smokeless tobacco use.

It was comforting to stakeholders to realise that similar processes were already in place to implement this recommendation; *"basically we already do this for smoking".* They stated that the standard question 'do you smoke' could easily be amended to 'do you use tobacco products', but that they would probably need resources such as visual aids and lists of local terms to support this.

An opportunity to refer to other relevant NICE guidance in this recommendation was also noted.

7.4 Practitioner time, motivation, and knowledge are key barriers to implementing this recommendation

Although stakeholders were able to see where this recommendation may fit with current smoking cessation practice, the key gap appears to be health professional monitoring systems and databases, which do not currently support asking patients about smokeless tobacco use. Impact could potentially be lost in the absence of recording being made mandatory and because of the wider financial constraints. Stakeholders noted that unlike smoking, there are no incentives for GPs to record smokeless tobacco use, and *"it would be useful to provide an incentive for GPs to provide advice, such as making this an additional QoF."*

The more motivated health professionals however will be more likely to implement this recommendation. One health professional noted that she has recorded use of smokeless products in a 'free notes' section of the recording template.

Stakeholders reflected on how some health professionals avoid asking the question which is a barrier to access of services. Stakeholders commonly asked the question *"do health professionals recognise the problem and probe, and can they offer advice in the time they give to a person?"* This may be a reflection of knowledge gaps and lack of confidence resulting from this.

> *"You don't want to bring it up if you don't know what you're talking about."*
> (Health professional)

Key changes to this recommendation

- Expand target audiences to include whole teams and secondary care.
- Remove reference to supporting quits and evaluating if brief intervention has ‘worked’. Retain focus of brief intervention on identification of smokeless tobacco use and awareness raising.
- Provide specific guidance on how to ‘ask the question’, revise product lists where appropriate and include reference to visual aids.

8 Recommendation 5: Training for practitioners

Recommendation summary

This recommendation is directed at health and dental services and the NHS Centre for Smoking Cessation and Training. It centres on training health professionals on awareness of smokeless tobacco use so that they are able to recognise signs and symptoms; use the appropriate product names; be sensitive to cultural issues; feel confident in providing information on health risks and misconceptions; deliver a brief intervention; and refer those people who want to quit to cessation services.

In general this recommendation was received as relevant and practical; although there were some examples of good practice in training for practitioners described, this was still new and not widespread. Focus group discussions revealed that the recommendation was not clearly understood, particularly in relation to target audiences. By contrast however, survey responses showed that most respondents either completely or mostly understood the recommendation. Survey responses also supported that this recommendation was thought to be useful, and some survey respondents thought the recommendation would improve their practice 'a little'.

In terms of language use, one stakeholder questioned the use of 'myths', commenting that this is not consistent with the theme of avoiding stigmatising South Asians. Since certain health benefits of smokeless tobacco products (e.g. morning sickness; digestive aid; constipation relief) may in fact be accurate, it was suggested that this term be replaced with 'beliefs'.

As previously noted, some stakeholders suggested that this recommendation should be repositioned to appear before recommendation 4, so that training is referred to before service provision.

Details of the feedback are given in the remainder of this Section, and key changes are summarised at the end of the Section.

8.1 Training was recognised as a key gap; this recommendation was welcomed

Although in a few areas training was not seen as a gap, the majority of stakeholders welcomed this recommendation and stated that training was not widely available on smokeless tobacco use. They felt that this was needed for all professional groups, especially in terms of improving knowledge and understanding of the various products which fit within this definition:

> *"We've had people come into the practice but they've spoke mainly to the patients in the waiting room. I've not personally had any advice given to me about how to then help people to stop."*

As noted in the feedback for recommendation 4, it was suggested that training for smokeless tobacco could readily be integrated into training for brief interventions in smoking cessation. Some commented that incorporating training within broader CPD will help increase access and uptake. It was also suggested that attaching accreditation to training and making this a pre-requisite for giving advice would increase application.

8.2 Target audiences could be better defined – stakeholders were unclear about who should be commissioning, delivering, and receiving training

Target audiences were not well understood as was shown by the considerable debate on who the audience was intended to be, and what the roles of these groups were. Essentially, three roles were identified in relation to training:

1) Commissioners of training;
2) Deliverers of training; and

3) Those receiving training.

Stakeholders thought that the recommendation as it currently stands does not clearly state these roles, and nor does it indicate what actions related to them.

Stakeholders were pleased to see the NHS Centre for Smoking Cessation and Training identified as a target audience. This was interpreted as a willingness for national action, which is what stakeholders thought was necessary for the recommendations as a whole.

Stakeholders thought that 'health and dental services' is too broad a definition, and that it should be further defined. They were also unclear what the role of these services was, and reflected that professionals in these services should be receiving training but not delivering it. There was strong agreement that training would best be delivered by tobacco specialists; *"could it recommend giving training to practitioners from the experts in the cessation services who work with the community?"* There was also some discussion of the NHS Centre's role in providing marketing material for local services to use.

Many additional target audiences were also thought relevant to this recommendation – although most of these could be included in the broad definition of 'health and dental services' – for example, dental therapists, district nurses, and mental health practitioners were all mentioned as specific groups which should be included. Stop Smoking services and public health consultants were also identified as relevant target audiences. Finally some stakeholders felt that it would be useful if community leaders could receive training, since they can act as role models once they have a fuller understanding of the health risks of smokeless tobacco. One stakeholder also thought that it might be useful for some staff in schools to receive training also.

8.3 Training should be standardised and should include content on how to carry out community engagement

Some stakeholders thought that the quality of training needs to be ensured by standardising content, which could be adapted for local relevance. Without this the risk is that there will be wide variation in content and quality, and inefficient duplication. The credibility which nationally recognised training holds will also help raise the profile of smokeless tobacco cessation. The forthcoming oral health toolkit was mentioned as an example of how this might be done.

Stakeholders also had views on the coverage of the training. It was suggested that *"the knowledge and understanding of local services* (is) *used"*, and that this should include increasing knowledge and understanding of smokeless tobacco products. Written material to supplement training was considered useful if it was to provide a *"straightforward pathway of what we need to do to refer and what happens then."*

It was also thought that training should cover the practicalities of how to effectively engage communities. This should focus on the heterogeneity of South Asians, and take into account the different approaches required for different age groups and genders.

Key changes to this recommendation

- Define target audiences better, clearly stating where guidance is recommended for commissioners, providers and receivers of training. Revise the list to reflect these target audiences and consider including community leaders and school nurses.
- Include guidance on training content; consider including product information, knowledge and understanding of cessation services, and guidance on how to 'do' effective community engagement.

9 Recommendation 6: Specialist cessation services in areas of identified need

Recommendation summary

This recommendation is directed to providers of primary and secondary healthcare (including those working in general practice, dental practices and pharmacies), and to staff working in community-based cessation services.

This recommendation refers to the provision of specialist cessation services, including ensuring that staff are appropriately trained, and that the service includes advice on coping with adverse effects, relapse prevention, validation of quit attempts, and monitoring for increase in smoking.

The recommendation also covers targeted services for particular groups where smokeless tobacco use is more prevalent (i.e. South Asian women), stating that socially isolated adults need to be identified and that outreach support should be offered. This final recommendation also suggests that local South Asian communities should be consulted to decide whether separately branded services or provision within mainstream services is more appropriate.

This recommendation was generally thought to be relevant and potentially practical – depending on available resources. Survey responses showed a good understanding of this recommendation. Most survey responses also showed that this recommendation's usefulness was rated highly, and there were some responses stating that the recommendation may improve practice 'a little'.

There was general agreement that the recommendation lacked detail, and as noted earlier, some thought that this recommendation was repetitive of recommendation 3 in its description of services.

Details of the feedback are given in the remainder of this Section, and key changes are summarised at the end of the Section.

9.1 Target audiences need to be defined better

Some revisions were suggested to target audiences for this recommendation. It was thought that 'community based cessation services' was vague; there was some disagreement among stakeholders about the relevance of this recommendation to all community based staff. It is therefore advisable that roles within this category are specified.

Additional stakeholder groups that this recommendation was thought to be relevant to include senior commissioners of services, such as directors of public health. This is because these are the people who are responsible for deciding if a service is commissionable in their locality. These stakeholders will also decide the strategic fit of services – such as whether they should sit within mainstream smoking cessation services.

9.2 More detail is required on the nature of services and how these should be commissioned

In general it was felt that this recommendation *"could have gone further"* in providing more detail on the nature of services and the difference between what a brief intervention and specialist services entail. Some specific comments about types of detail needed were, that:

- Stakeholders noted that NRT therapy has received no mention in the recommendations. While there was some recognition that there may not be clear evidence for its use with smokeless tobacco users, it was still thought to be useful to have guidance on its use. This could be included in the third bullet point which focuses on relapse prevention and follow up;
- It was also noted among those who have experience of delivering smokeless tobacco services, that quitting smokeless tobacco does not usually lead to take-up of smoking –

although the reverse pattern is common: for smokers to quit and start using smokeless tobacco; and

- More detail of services could be included in the fifth bullet point, where there should be guidance on accessible services in terms of flexibility about the provision of one-to-one and group therapy services.

9.3 Language specific material is not necessarily valuable for improving access to services

Many stakeholders discussed the 'added value' of translating materials into community languages. A number of stakeholders noted that it is common for South Asians who cannot read English to be illiterate in their own languages also. Although a dissenting view was that even when people cannot read their own language they can identify it, which communicates a message of relevance to particular communities. In some areas there has been a move away from translating materials, and some stakeholders noted that when they did this in the past it did not substantially improve access to services.

Other methods of communicating information were deemed to be more effective than translated written material; *"it's about being armed with the right information".* These included the use of visual aids (e.g. pictures of the products), and the use of relevant local TV and radio stations. The face-to-face method of raising awareness through information sharing events in community venues, such as mosques, was thought to be the most favourable method of improving access to information.

9.4 The cost of certain elements of the recommended service presents a barrier to implementation

Stakeholders discussed many barriers for implementing this recommendation which relate to cost; *"the services that can be supplied are restricted by cost."* The most commonly discussed were home visits, validating quits, and providing separately branded services.

9.4.1 Home visits are costly and reach can be greater in alternative service models

Home visits proved to be a contentious subject for stakeholders, who described this service as too costly for the potential benefit it might reap. As one focus group attendant noted, home visits require risk assessment and the presence of two members of staff – which constitutes a very costly service.

Although some questioned whether home visits were effective, others who had run this service already described better success rates for engaging people in one-to-one support in their own homes. One provider described how although he would like to deliver a home visit service, his *"service manager said* (we) *cannot afford to do home visits as* (we) *can provide advice to more people by providing services in clinics or community halls."*

A few stakeholders noted that smokeless tobacco cessation support could be built into home visits already provided by health professionals – for example GP and dental care teams.

9.4.2 The cost of validating quits will make this recommendation difficult to implement

Many stakeholders raised the expense of validation kits as a barrier to implementation, and some stated that it was less important to validate quits for smokeless tobacco. In one group discussion it was stated that *"validating quit attempts has been done this way in the past but* (it) *was very expensive. There needs to be resources attached to these recommendations or cotenine tests are unlikely."*

In this group there was a discussion of cheaper alternatives to cotenine testing kits, such as biomarkers for tobacco use during NRT. Anabasine and anatabine concentrations in urine can be used to validate abstinence or measure the extent of tobacco use in persons undergoing NRT.

9.4.3 Separately branded services cannot be financed because of the current economic challenges faced by the public sector

In general, support for separately branded services was low. Some stakeholders stated that it was not relevant to ask the community if they would prefer this option as suggested in the recommendation, because it would not be feasible to deliver this service model:

> *"In an ideal world you would ask the local community what they would like – separately branded services or mainstreamed – but you're asking them about something you won't be able to deliver."*

Stakeholders preferred instead for smokeless tobacco cessation to be integrated into Stop Smoking services – albeit with some tailoring of approach to ensure appropriateness for target communities. There were also suggestions that this service could be strategically situated within broader drugs and alcohol services.

Examples of existing practice evidenced the effectiveness of an integrated model. Although this model requires smokeless tobacco specialists who are sensitive to the cultural context. Stakeholders noted that it is preferable to make service personnel more appropriate than to have separately branded services:

> *"Most people don't know who provides services, they know they go and see a dentist or a GP, but they don't know the background of commissioning. They just know that they are getting a service."*

Key changes to this recommendation

- Revise target audience list to specify job roles. Consider widening the list to include commissioners.
- Amend to include more detail of recommended services, including different types of therapy such as use of NRT, group therapy, and one-to-one therapy. Provide a clear description of brief intervention and specialist therapy, and delineate the difference between these.
- Include reference to a broader set of methods for improving access to services.
- Revisit whether validation of cessation is required, and if so, consider recommending alternative more cost effective methods of achieving validation.
- Revise guidance on 'separately branded' services; consider that it is more practical to have the services integrated within a broader 'tobacco cessation' branding, with inclusion in teams of smokeless tobacco specialists who have an understanding of the cultural context.

ANNEXES

Annex 1 Bibliography

ASH. (2011). *Fact Sheets: Tobacco and Ethnic Minorities*, September 2011.

Cancer Research UK. (2011). *Cancer incidence for common cancers - UK statistics* (Cancer Stats) [online] (Updated 4th May 2011) Available at: http://info.cancerresearchuk.org/cancerstats/incidence/commoncancers/#Twenty. [Accessed 15th Nov 2011].

Cooper, H., Arber, S., Jinn, J. and Smaje, C. (2000). *Ethnic Inequalities in Health and Smoking Behaviour*, NHS Health Development Agency.

Department of Health. (2007). *Cancer Reform Strategy.* Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_081007.pdf. [Accessed 20th March 2012].

Department of Health. (2010a). *Healthy Lives, Healthy People: Our strategy for public health in England.* Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127424.pdf. [Accessed 20th March 2012].

Department of Health. (2011a). *The NHS Outcomes Framework 2012/13.* Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131723.pdf. [Accessed 20th March 2012].

Department of Health. (2011b). *The Operating Framework for the NHS in England 2012/13.* Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131428.pdf. [Accessed 20th March 2012].

HM Government. (2011). *Healthy Lives, Healthy People: A Tobacco Control Plan for England.* Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124960.pdf. [Accessed 20th March 2012].

London Health Observatory, 2011, *Smoking* [online] Available at: http://www.lho.org.uk/LHO_Topics/National_Lead_Areas/Smoking.aspx [Accessed 15th November 2011].

NHS. (2005). *Health Survey for England 2004: The Health of Minority Ethnic Groups–headline tables*, Health and Social Care Information Centre.

Annex 2 Focus group/interview discussion guide

Points to note for facilitators

Mixed groups

Each fieldwork focus group will consist of a different group of professionals or practitioners; there is likely to be a mix of commissioners, providers, primary care-givers, and representatives from voluntary and community groups present.

Be aware of the composition of each group and the particular issues within the recommendations that may concern them. For example recommendations 1 and 3 (assessing need and planning services) may be more suited to commissioners and public health specialists, and recommendation 4 (brief advice/referral) may be more relevant for primary care-givers.

Use of discussion guides

The discussion guides are intended to be used flexibly, and where there is particular interest from a group or interviewee in discussing one or more aspects of the guidance, this should be encouraged. Where it is helpful for the respondents, the recommendations can be covered in any order.

Note however that **all the core questions must be covered during the fieldwork**, and approximate times are given for each section, based on a two hour focus group. It is suggested that the 'general' questions are asked first in order to gather overall views on the recommendations before specific questions are asked. We know that some focus groups will be shorter and will need to be tailored to the time that participants can commit to.

Materials to use – focus groups

All focus groups will be recorded for audit purposes, and attended by a **lead facilitator** (whose role it is to conduct the focus group) and a **scribe**. Notes will be handwritten, and some additional tools for recording data are contained in Annexes 2-4.

Researchers need the following for use during the focus groups:

- Dictaphone;
- A1 paper and post-it notes – to be used to record respondents' ideas;
- The full draft NICE guidance document;
- Sign in and equalities monitoring sheets;
- Consent letters; and
- Spare pens.

Materials to use – interviews

Interviews only require pen and paper, and the full draft NICE guidance document.

Managing time

Researchers should actively manage time throughout the consultation. In particular, warm up exercises should be limited in order to give participants the maximum possible time to respond.

10 m	Introduction
	Introduce GHK, the facilitator (and scribe). **Introduce NICE and why the focus group / interview is taking place:** ▪ Why the recommendations for helping South Asians to stop using smokeless tobacco are being produced (see the draft scope in project folder). You may draw on the following points when presenting this rationale: – Understanding of, and services for smokeless tobacco use are limited; – This behaviour is concentrated in South Asian populations; – There are certain cultural sensitivities which may affect tobacco use, and services will need to be cognisant of these; and – The awareness of health risk associated with this behaviour is still low. ▪ Why the audience's input is **important and valued** '*this is your opportunity to influence national recommendations on smokeless tobacco use…*', and how it contributes to the development of the final recommendations. ▪ Remind participants that they are taking part on the basis that they are sharing their **personal views as a practitioner**; we are not asking them to represent their organisations in this fieldwork. **If their organisations do want to formally contribute**, then they can submit organisational views through the formal stakeholder consultation process being managed by NICE. This can be done by visiting the NICE website at: http://www.nice.org.uk/guidance/index.jsp?action=folder&o=58276 ▪ Also be prepared to explain a little about the process by which the recommendations were developed and the evidence. See NICE process manual in the project folder. **Introduce consent and confidentiality** ▪ Focus groups will be recorded for audit purposes; and ▪ All views will be treated in confidence and anonymised; neither individuals nor their organisations will be named. **Hand out sign-in and equalities monitoring sheets for completion. Also hand out consent letters for signing if there are any participants who have not already returned these.** ▪ Offer respondents the opportunity to ask questions at any point **Ask whether participants have read the draft recommendations** - If most have not, explain that they will be introduced as the focus group progresses (ensure copies of the recommendations are at hand).
5 m	**Warm up**
	Respondents to introduce self, role and responsibilities Have you heard of NICE and what would you expect NICE's involvement in this area to achieve? How optimistic do you feel that this guidance can improve support for South Asians to stop using smokeless tobacco? What are the main problems, in your view? In relation to the following sections, ask respondents to think about examples

	when feeding back on the individual recommendations.
Approximately 15 m	**Recommendation 1: Assessing local need**
	[Be prepared to start with a general question and follow up respondents' feedback throughout] **Is the recommendation easily understood and clearly worded?** **Will this recommendation help you, and your colleagues, in your efforts to improve health outcomes for South Asian groups?** **- is this recommendation relevant and <u>useful</u> to you in the services you work for?** **- What <u>impact</u> might it have on current or future services or policy?** **- What <u>factors</u> might influence its implementation or effectiveness?** **- What <u>factors</u> might impact (positively or negatively) on its implementation?** **Who should take action on this recommendation? (Prompt for views on whether the 'who should take action' list is comprehensive)** ***Possible prompts if needed:*** ▪ If any, what challenges do you face in collecting and analysing local data from South Asian communities to record prevalence, incidence, and associated health problems?
Approximately 15 m	**Recommendation 2: Working with local South Asian communities in areas of identified need**
	Is the recommendation easily understood and clearly worded? **Will this recommendation help you, and your colleagues, in your efforts to support those of South Asian origin to achieve positive health outcomes?** **- is this recommendation relevant and <u>useful</u> to you in the services you work for?** **- What <u>impact</u> might it have on current or future services or policy?** **- What <u>factors</u> might influence its implementation or effectiveness?** **- What <u>factors</u> might impact (positively or negatively) on its implementation?** **Who should take action on this recommendation? (Prompt for views on whether the 'who should take action' list is comprehensive)** ***Possible prompts if needed:*** ▪ How practical is it to involve local South Asian communities in planning, design and coordination of activities to help them stop using smokeless tobacco? ▪ What do you anticipate might be potential barriers to raising awareness of local smokeless tobacco cessation services? Are there enough services? ▪ What, if any challenges do you envisage in attempts to address misconceptions about potential health problems from using these products?
Approximately 15 m	**Recommendation 3: Planning and providing services in areas of identified need**

	Is the recommendation easily understood and clearly worded? **Will this recommendation help you, and your colleagues, in your efforts to improve health outcomes for South Asian groups?** **- is this recommendation relevant and <u>useful</u> to you in the services you work for?** **- What <u>impact</u> might it have on current or future services or policy?** **- What <u>factors</u> might influence its implementation or effectiveness?** **- What <u>factors</u> might impact (positively or negatively) on its implementation?** **Who should take action on this recommendation? (Prompt for views on whether the 'who should take action' list is comprehensive)** ***Possible prompts if needed:*** ▪ What do you see as the challenges to commissioning the right 'mix and range' of local smokeless tobacco cessation services for South Asians? ▪ Is it feasible to integrate smokeless tobacco cessation services within broader smoking cessation activities, and to link these to national stop smoking services? ▪ What would the challenges be for monitoring and evaluating cessation services by the outcomes defined in this recommendation? Are they the right outcomes?
Approximately 15 m	**Recommendation 4: Providing brief advice and referral: dentists, GPs, pharmacists and other health professionals**
	Is the recommendation easily understood and clearly worded? **Will this recommendation help you, and your colleagues, in your efforts to improve health outcomes for South Asian groups?** **- is this recommendation relevant and <u>useful</u> to you in the services you work for?** **- What <u>impact</u> might it have on current or future services or policy?** **- What <u>factors</u> might influence its implementation or effectiveness?** **- What <u>factors</u> might impact (positively or negatively) on its implementation?** **Who should take action on this recommendation? (Prompt for views on whether the 'who should take action' list is comprehensive)** ***Possible prompts if needed:*** ▪ What are the barriers to health professionals routinely asking and recording smokeless tobacco use habits? How might these be overcome? ▪ How prepared are health professionals to provide brief advice and onward referral? What are the barriers, and how might these be overcome?
Approximately 15 m	**Recommendation 5: Training for practitioners**
	Is the recommendation easily understood and clearly worded? **Will this recommendation help you, and your colleagues, in your efforts to improve health outcomes for South Asian groups?** **- is this recommendation relevant and useful to you in the services you**

	work for? **- What <u>impact</u> might it have on current or future services or policy?** **- What <u>factors</u> might influence its implementation or effectiveness?** **- What <u>factors</u> might impact (positively or negatively) on its implementation?** **- Who should take action on this recommendation? (Prompt for views on whether the 'who should take action' list is comprehensive)** ***Possible prompts if needed:*** ▪ To what extent do practitioners receive the relevant training, and how easy would it be to supplement current training with this? ▪ How skilled are practitioners in: recognising the signs and symptoms of smokeless tobacco use; being sensitive to cultural issues; feeling confident in providing information on health risks of smokeless tobacco use; and delivering brief intervention?
Approximately 15 m	**Recommendation 6: Specialist cessation services in areas of identified need**
	Is the recommendation easily understood and clearly worded? **Will this recommendation help you, and your colleagues, in your efforts to improve health outcomes for South Asian groups?** **- is this recommendation relevant and <u>useful</u> to you in the services you work for?** **- What <u>impact</u> might it have on current or future services or policy?** **- What <u>factors</u> might influence its implementation or effectiveness?** **- What <u>factors</u> might impact (positively or negatively) on its implementation?** **Who should take action on this recommendation? (Prompt for views on whether the 'who should take action' list is comprehensive)** ***Possible prompts if needed:*** ▪ How practical is it to implement and commission specialist services for smokeless tobacco use, which include targeted services and home outreach? ▪ What are the pros and cons of providing services targeting particular groups and sub-groups? ▪ If any, what are the challenges to gathering the views and experiences of local South Asian communities to understand their concerns and needs in relation to smokeless tobacco?
10 m	**General overview**
	▪ How relevant are these recommendations to your day to day practice? Why? ▪ To what extent will these recommendations influence your practice or the practice of your organisation? Why? ▪ How practical is it to implement these recommendations overall? Is it realistic to implement them – are you confident that they would work? ▪ What are the biggest barriers likely to be? How can these be overcome? ▪ Do you think there are any gaps in the coverage of these recommendations? What are they? ▪ How easy is it to understand the recommendations? How clear is the wording? ▪ Do these recommendations overlap each other or duplicate any existing guidance relating to smokeless tobacco cessation?

	▪ Are there any potential negative impacts of these recommendations? Why? ▪ Did anything surprise you in relation to the content of the guidance? ▪ What could NICE do to raise awareness of the recommendations and communicate them to your professional group? ▪ Do you have any more comments about the recommendations?
5 m	**Close and thank respondents for their time**
	Remind participants to **leave sign in sheets, equalities monitoring forms, and consent forms behind** and make sure these are collected at the exit. **Give participants notice that we will send them a summary of the main points and themes that emerged from the focus group, to give them the opportunity to check them for accuracy/ comment on them if they wish to do so.** Ensure that the **event organiser is thanked** and that any expenses for catering are collected.

Annex 3 Web survey

[Informed consent and introduction to the fieldwork]

Please refer to the draft guidance when answering this question. If you do not have a copy to hand, this can be accessed here. You can print this off for reference as you complete the survey.

Q1 Thinking about the recommendations in the draft guidance, please select the option that you agree with most.

	I think this is written clearly and I understand it completely	I think that I understand most of this and what it is asking me to do	I don't understand most of this and what it is asking me to do	I think this is not written clearly and I do not understand it at all	I have no opinion
The draft guidance document as a whole					
1.Assessing local need					
2.Working with local South Asian communities in areas of identified need					
3. Planning and providing services in areas of identified need					
4. Providing brief advice and referral: dentists, GPs, pharmacists and other health professionals					
5. Training for practitioners					
6. Specialist cessation services in areas of need					

Q2 What would make the guidance document as a whole more clear and easy to understand?

Q3 Thinking about the recommendations in the draft guidance, please select the option that you agree with most.

	This is very useful to me in my work	This is somewhat useful to me in my work	This is not particularly useful to me in my work	This is not at all useful to me in my work	I have no opinion
The draft guidance document as a whole					
1.Assessing local need					
2.Working with local South Asian communities in areas of identified need					
3. Planning and providing services in areas of identified need					
4. Providing brief advice and referral: dentists, GPs, pharmacists and other health professionals					
5. Training for practitioners					
6. Specialist cessation services in areas of					

identified need					

Q4 Thinking about the recommendations in the draft guidance, please select the option that you agree with most.

	This will improve how I work a great deal	This will improve how I work a little	This will not improve how I work	This will be detrimental to how I work	I don't know / I have no opinion
The draft guidance document as a whole					
1.Assessing local need					
2.Working with local South Asian communities in areas of identified need					
3. Planning and providing services in areas of identified need					
4. Providing brief advice and referral: dentists, GPs, pharmacists and other health professionals					
5. Training for practitioners					
6. Specialist cessation services in areas of identified need					

Q5 What changes to the guidance as a whole would make it more likely to improve your day to day approach to work? *(E.g. In terms of coverage and any gaps in this, and practicality of implementing the guidance).*

Q6 Please choose the subjects for recommendations that are especially important for you and your role, and click 'next' to give us more detailed feedback if you wish.

	This is particularly important for me
1. XXXX	
2. XXXX	

Q7 Is this recommendation appropriate, relevant and useful to you and your day to day practice? Please tell us why / why not?

Free text

Q8 What are the likely consequences of this recommendation for service users?

Free text

Q9 Is the advice given with this recommendation useful?

Free text

Q10 Is the advice given with this recommendation comprehensive?

Free text

Q11 Are there any gaps in this recommendation?

Free text

Q12 Are there more appropriate processes and methods that could be used instead to achieve what this recommendation is trying to achieve?

Free text

Q13 How practical is it to implement this recommendation, and collect relevant evidence to show that the activities are taking place?

Free text

Q14 What are the biggest barriers to implementing this recommendation likely to be, in your organisation? How can these be overcome?

Free text

Q15 How clear is the wording and style of the recommendation? How could clarity of the advice be improved?

Free text

Q16. Is the recommendation suitable for the different audiences identified? Should anyone else be included?

Free text

[Descriptive: About you]

[Equalities monitoring – see Annex 4]

[Thanks and close]

Annex 4 Focus group sign-in sheet

These should be completed by all participants at the start of the focus groups, and collected by researchers before leaving. The sign in sheet ensures that GHK correctly understand respondents' job roles and characteristics. These should be recorded on the project spreadsheet.

Please fill in the following sheet (this is more than one page long) in order that we can know a little more about the background of people attending today:

Your name: _____

Your role: _____

Your organisation: _____

Email: _____

Q1. Please tick the category which **best describes** your role**:**

Based **full-time or part-time in a community** setting and **employed by the NHS.**	
Based **full-time or part-time in a primary care clinical** setting and **employed by the NHS.**	
Based **full-time or part-time in a hospital** setting and **employed by the NHS.**	
Based **full-time or part-time in a community** setting and **employed by/volunteering in a voluntary/faith organisation, or social enterprise.***	
Based **full-time or part-time in a primary care clinical** setting and **employed by/volunteering in a voluntary/faith organisation or social enterprise.**	
Based **full-time or part-time in a hospital** setting and **employed by/ volunteering in a voluntary/faith organisation or social enterprise.**	
Based **full-time or part-time in a community** setting and **employed by a local authority.**	
Based **full-time or part-time in an NHS trust** Public Health department.	
Based **full-time or part-time in a Local Authority** Public/Environmental Health department.	
Based **full-time or part-time in any other Local Authority** department – **Please specify.**	
Other, please describe:	

***** A social enterprise can be defined as a business with primarily social objectives, where profits are principally reinvested for that purpose.

Q2. Please tell us if your role covers the following responsibilities **– please tick all that apply:**

Providing services specific to preventing and stopping smokeless tobacco use	
Providing brief advice and/or referral for smoking cessation/tobacco use, (e.g. in your role as a primary health care professional)	
Providing specialist services for smoking cessation/tobacco use	
Primary health care provision without any responsibility for advice (brief or specialist), and/or referral for smoking cessation/tobacco use	
Provider of other public health services	
Outreach and community liaison	
Commissioner of services specific to preventing and stopping smokeless tobacco use	
Commissioner of smoking cessation or tobacco control services	
Commissioner of Public Health services	
Public Health specialist, researcher or academic	
Smoking cessation/tobacco use training for practitioners	
Senior management role responsible for public health strategy design and policy-making	
Other leadership role, such as role which mainly involves coordinating services, clinical care or commissioning	
Other not mentioned above (please give brief description of your role below):	

Q3. Please tick the following boxes if your main job includes regularly working with, or coordinating services for any of the following groups **– please tick as many boxes as you need to:**

Adults from various South Asian backgrounds (no specific groups)	
Adults from an Indian background	
Adults from a Pakistani background	
Adults from a Bangladeshi background	
Adults from a Nepalese background	
Adults from a Sri Lankan background	

Young adults from a South Asian background (aged 18-25 years)	
Older adults from a South Asian background (aged 60+)	
South Asian adults from disadvantaged households	
None of the above	

Q.4 Do you have a particular responsibility for tobacco control or Stop Smoking services with people of South Asian background?

Yes		No	

Annex 5 Equalities monitoring form

These should be should be completed by all participants at the start of the focus groups with the sign in sheet, and collected by researchers before leaving. The equalities monitoring form ensures that GHK collect data on the characteristics of respondents that feed back. Characteristics should be recorded on the project spreadsheet.

Equalities Monitoring Form

Please fill in the following sheet in order that we can know a little more about the background of people attending today:

Your name: _____

Your role: _____

Your organisation: _____

Gender: _____

What is your ethnic group?

White – British	
White – Any Other White background	
Mixed - White and Black Caribbean	
Mixed - White and Black African	
Mixed - White and Asian	
Mixed - Any Other Mixed background	
Black or Black British - Caribbean	
Black or Black British – African	
Black or Black British – Other Black background	
Asian or Asian British – Indian	
Asian or Asian British - Pakistani	
Asian or Asian British - Bangladeshi	
Asian or Asian British – Nepalese	
Asian or Asian British – Sri Lankan	
Asian or Asian British – Any Other Asian background	
Chinese or other ethnic group - Chinese	
Chinese or other ethnic group – Any Other ethnic group	
I prefer not to say	

Do you consider yourself to have a disability?

Yes	
No	
I prefer not to say	

Annex 6 Recruitment templates

A6.1 Invitation letter

[Insert date]

[Insert Name & address details]

Dear [insert contact name]

Re. National Institute for Health and Clinical Excellence, (NICE) Fieldwork on the draft guidance for helping people of South Asian origin to stop using smokeless tobacco

Thank you for speaking to our researcher, [insert name], on [date]. NICE and GHK Consulting very much appreciate your interest in taking part in the fieldwork.

NICE is committed to improving the quality of its guidance, by listening to the views of experienced, knowledgeable people in local areas across England. GHK is an independent social research consultancy which has been commissioned by NICE to conduct the fieldwork for the smokeless tobacco use guidance.

Engaging practitioners in the fieldwork is an integral part of the process by which NICE guidance is produced. Practitioner participation will help NICE to refine its draft recommendations on how to help people of South Asian origin stop using smokeless tobacco.

The guidance is currently being developed by the Public Health Interventions Advisory Committee (PHIAC), and consists of a set of recommendations for providers of smoking and tobacco cessation services, health and social care practitioners and all those with public health as part of their remit. The draft guidance was published for public consultation on the 23rd February 2012, and the NICE public consultation period will run from this date until the 24th April.

The fieldwork is being carried out by GHK on behalf of NICE, alongside the wider public consultation being managed by NICE. Participation in this fieldwork is being requested on the basis that participants share their **personal views as practitioners**; we are not asking participants to represent their organisations in this fieldwork. Practitioners have the opportunity to formally contribute organisational views by submitting comments through the formal stakeholder consultation process being managed by NICE. This can be done by visiting the NICE website here.

Your participation and the participation of other primary care, public health and third sector representatives in this fieldwork will help to test the relevance, usability and acceptability of the draft guidance and recommendations before they are finalised and published.

As part of the fieldwork, we are carrying out a focus group in [insert name of PCT area]. We are involving a wide range of practitioners in this focus group. We would like to include practitioners ranging from those who play a planning and commissioning role, to individuals who provide cessation services, as well as staff in community settings with public health in their remit. We have been working to recruit a sample which includes three main professional groups that are relevant to helping people of South Asian origin to stop using smokeless tobacco. These three groups are:

1) Primary care professionals;

2) Voluntary and community sector representatives; and

3) Public health managers, planners, and commissioners.

The focus group/interview [delete as appropriate] will be held at

[Location and address] on **[date and time]**.

Thank you for offering to assist us with the organisation of the venue [insert sentence if required for gatekeepers].

If you participate in the interview / focus group [delete as appropriate], this will be recorded by a digital recorder. The recordings and notes taken by the researcher(s) will be analysed by the research team at GHK and handled in accordance with best practice. The transcripts will be held securely and destroyed after five years. The interview / focus group [delete as appropriate] will last no longer than [time], but you have the right to end early if it is inconvenient, or talk for longer if you wish.

The final report which outlines the fieldwork findings will be used by NICE to inform a final version of its recommendations to practitioners, and the report will be published on the NICE website.

Your identity will not be revealed at any point in the research or the final report. Although GHK may quote you, all comments will be anonymised and will not identify you or your organisation within the report. Anything you tell us will be treated in the strictest confidence.

GHK will provide you with a copy of the draft guidance for your consideration closer to the interview / focus group [delete as appropriate].

If you have any questions regarding this fieldwork or your rights as a research participant, you can contact Oliver Jackson at oliver.jackson@ghkint.com or by telephone on 0121233 8900.

Yours sincerely

[Insert name of GHK researcher]

A6.2 Consent letter

[Insert date]

[Insert Name & address details]

Dear [insert contact name]

Re. National Institute for Health and Clinical Excellence, (NICE) Fieldwork on Draft Guidance for Helping People of South Asian Origin to Stop Using Smokeless Tobacco

Consent to Participate in Research – PLEASE SIGN AND RETURN

Location and address of focus group: <<insert address>>

Date and time of focus group: <<insert date of focus group>>

As part of the National Institute for Health and Clinical Excellence (NICE – www.nice.org.uk) fieldwork process, we are carrying out research in <<insert PCT area>>. We would like to know your views as a practitioner so that NICE's recommendations on **helping people of South Asian origin to stop using smokeless tobacco** are relevant, appropriate, useful, feasible and implementable.

NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. The objective of NICE's public health guidance is to bring about social, economic, organisational, community and individual change to improve health and reduce inequalities in health. Consulting practitioners through fieldwork is an integral part of the process in which NICE guidance is produced.

Participation in this fieldwork is being requested on the basis that participants share their **personal views as practitioners**; we are not asking participants to represent their organisations in this fieldwork.

If you agree to participate in the fieldwork, you will be asked to take part in a focus group, which will be recorded by a digital recorder. The recordings will be handled in accordance with best practice, and transcripts will be held securely and destroyed after five years. The focus group will last no longer than the allotted time, but you have the right to end early if it is inconvenient, or talk for longer if you wish.

The final research report produced as a result of the analysis will be used by NICE to produce a final version of its recommendations to practitioners, and the research report may be published on the NICE website.

Your identity will not be revealed at any point in the research or in the final report. Although GHK may quote you, all comments will be confidential and will not be identifiable to yourself or your organisations within the research report.

GHK will provide you with a copy of the draft NICE guidance closer to the interview / focus group (delete as appropriate).

If you have any questions regarding this fieldwork or your rights as a research participant, you can contact Oliver Jackson at oliver.jackson@ghkint.com or by telephone on 0121233 8900.

Placing your signature below indicates that you have read and understood the information provided above, that you willingly agree to participate, that you understand your right to discontinue participation at any point, and that you have received a copy of this form.

Printed Name_____**Organisation**_____

Signature_____**Today's Date** _____

Phone Number_____**Email**_____

Please fax or post this form to the address below. You may use the self-addressed envelope enclosed.

GHK Consulting, 30 St Paul's Square, Birmingham, B3 1QZ.

Fax: +44 (0)121 212 0308

A6.3 Email to gatekeepers for survey participants

Subject: NICE field testing of recommendations for 'Helping people of South Asian origin to stop using smokeless tobacco.'

Dear **[insert name]**

Thank you for speaking with me earlier, and for agreeing to provide us with contact details of people in your organisation who might be able to contribute to our fieldwork. The fieldwork will test the forthcoming **National Institute of Health and Clinical Excellence (NICE)** draft guidance for '**Helping people of South Asian origin to stop using smokeless tobacco.'**

NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. NICE is committed to improving the quality of its guidance, by listening to the views of experienced, knowledgeable people in local areas across England. GHK is an independent, social research consultancy which has been commissioned by NICE to undertake the fieldwork. NICE and GHK Consulting appreciate your interest in taking part in the fieldwork.

The guidance is currently being developed by the Public Health Interventions Advisory Committee (PHIAC), and consists of a set of recommendations for providers of smoking and tobacco cessation services, health and social care practitioners and all those with public health as part of their remit. The draft guidance was published for public consultation in the week commencing 23rd February 2012, and the NICE public consultation period will run from this date until the 24th April. The draft guidance is available here.

This fieldwork is being carried out by GHK on behalf of NICE, alongside the wider public consultation being managed by NICE. Participation in this fieldwork is being requested on the basis that participants share their **personal views as practitioners**; we are not asking participants to represent their organisations in this fieldwork. Practitioners have the opportunity to formally contribute organisational views by submitting comments through the formal stakeholder consultation process being managed by NICE. This can be done by visiting the NICE website here.

Your participation and the participation of other primary care, public health and third sector representatives in this fieldwork will help to test the relevance, usability and acceptability of the draft guidance and recommendations before they are finalised and published.

At this stage, we would be very grateful if you could provide us with the names and contact details of those practitioners who might be able to take part in the survey – we attach a document which lists practitioners we would like to invite to complete the survey. We will then send them a link, via email, so that they can access the survey in March 2012. It is preferable for us to have direct contact with survey participants so that we can send them the link, together with updates and reminders.

If there is anything that you could do to raise awareness among your colleagues of the fieldwork, that would also be appreciated (such as forwarding this email, or mentioning the fieldwork at meetings).

Your assistance, and your views and experience would be valuable in ensuring that the guidance is informed by the knowledge and experience of practitioners in this field. Please contact me by email or telephone if you require any further information before deciding whether to take part. Please could you respond by **[insert date]**.

Thank you again for your assistance in our work, and I look forward to hearing from you soon.

[Researcher name, contact details]

A6.4 Email to survey participants

Subject: NICE field testing of recommendations for 'Helping people of South Asian origin to stop using smokeless tobacco.'

Dear Colleague

The **National Institute for Health and Clinical Excellence (NICE)** has commissioned GHK to conduct field testing on its forthcoming draft guidance for helping people of South Asian origin to stop using smokeless tobacco.

NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. NICE is committed to improving the quality of its guidance, by listening to the views of experienced, knowledgeable people in local areas across England. GHK is an independent, social research consultancy which has been commissioned by NICE to undertake the fieldwork. NICE and GHK Consulting appreciate your interest in taking part in the fieldwork.

The guidance is currently being developed by the Public Health Interventions Advisory Committee (PHIAC), and consists of a set of recommendations for providers of smoking and tobacco cessation services, health and social care practitioners and all those with public health as part of their remit. The draft guidance was published for public consultation in the

week commencing 23rd February 2012, and the NICE public consultation period will run from this date until the 24th April. The draft guidance is available here.

This fieldwork is being carried out by GHK on behalf of NICE alongside the wider public consultation being managed by NICE. Your participation in this fieldwork is being requested on the basis that you share your **personal views as a practitioner**; we are not asking you to represent your organisation in this fieldwork. You have the opportunity to formally contribute organisational views by submitting comments through the formal stakeholder consultation process being managed by NICE. You can do so by visiting the NICE website here.

Considering your professional involvement or interest in smokeless tobacco use in those of South Asian origin, we would like to **invite you to respond to an online survey found here**:

https://stusurvey.ghkint.com/

Please complete the survey by **[Insert 2 week deadline].**

Your participation in this fieldwork will help NICE to examine the relevance, usability, acceptability and implementability of its draft recommendations, before they are finalised and published.

We are also interested in gathering responses from a range of other professionals. A comprehensive list of potential participants is attached to this email. If you know people who fit this criteria and whom you feel may be interested in taking part in the research, please forward this email on to them, or send us their contact details.

Thank you very much in advance for your time and interest. Please do not hesitate to ask me any questions regarding the purpose or content of the study.

Yours sincerely

[Researcher name, contact details]

A6.5 Document attached to gatekeeper e-mail correspondence

Thank you for agreeing to **[provide us with contact details of people/send this to other relevant people – delete as appropriate]** in your organisation who might be able to contribute to our field testing on the subject of forthcoming National Institute of Health and Clinical Excellence (NICE) draft guidance for '**Helping people of South Asian origin to stop using smokeless tobacco.'**

We are mainly interested in receiving input from **people from each of the following groups:**

Primary care professionals:

- GPs
- Nurses
- Midwives
- Health visitors
- Dentists
- Dental nurses
- Community pharmacists
- Stop Smoking Service advisors
- Private sector smoking cessation advisors
- Health trainers

Public health managers, planners and commissioners:

- PCT commissioners
- NHS managers

- Tobacco control / smoking cessation leads
- Outreach/community engagement
- GPs in clinical commissioning groups
- Directors of Public Health or their deputies
- Environmental health officers

Voluntary and community sector representatives:

- Health/education charities/community groups
- Community/religious leaders
- Community champions
- Peer educators
- Others working with South Asian groups, particularly Bangladeshis

Annex 7 Analytical tools

A7.1 Focus group/interview write up

Date & Time: **Region:**		
Recommendation 1 (etc.)	*What was said*	*By who (give number of practitioners where possible))*
Is it relevant?		
Is it practical to implement?		
What are the barriers?		
Current practice		
Likely impact on practice		
Gaps in the content of recommendation		
Gaps in the list of target groups for this recommendation		

Clarity of <u>wording</u> of recommendation		
Other comments		
<u>Conclusions for the Recommendation</u> ***(Give your view of what the implications are for NICE!)***		
General overview	*Evidence given*	*By who (give number of practitioners where possible)*
Relevance of recommendations		
Clarity of wording		
Perception of NICE's involvement		
Additional resources needed to implement?		
Dissemination		

Conclusions ***(what is your view on what NICE need to change – for internal use)N.B. The Summary sheet below is a summary for sending to the focus group participants***		

A7.2 Summary Sheet

Date & Time:

Region / Local Authority Area:

Overall view on whether recommendations are useful or not and why
Overall view on barriers to implementation
Main gaps identified in the recommendations
Good practice identified

A7.3 Data recording sheet: key quotes

Date & Time:

PCT Area:

Time	Quote	What point does this illustrate?
10’30’’	“Recommendation 1 is helpful”	XXX