NHS STOP SMOKING SERVICES

Service and monitoring guidance 2009/10

SMOKEFREE

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Service and monitoring guidance 2009/10

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ABBREVIATIONS

BME	Black and minority ethnic
CLG	Communities and Local Government
CO	Carbon monoxide
COPD	Chronic obstructive pulmonary disease
CRM	Customer relationship management
CVD	Cardiovascular disease
DDA	Disability Discrimination Act
DH	Department of Health
FTND	Fagerström test for nicotine dependence
HCP	Healthcare professional
HDA	Health Development Agency
HSE	Health and Safety Executive
IC	NHS Information Centre
IDeA	Improvement and Development Agency
IHS	Integrated Household Survey
LA	Local authority
LAA	Local Area Agreement
LCFS	Local counter-fraud specialist
LES	Local Enhanced Service
MHRA	Medicines and Healthcare products Regulatory Agency
NARS	Nicotine-Assisted Reduction to Stop
NICE	National Institute for Health and Clinical Excellence
NNT	Numbers needed to treat
NSEC	National Statistics Socio-Economic Classification
NST	National support team
NRT	Nicotine replacement therapy
NZGG	New Zealand Guidelines Group
PCT	Primary care trust
PSA	Public Service Agreement
ONS	Office for National Statistics
QOF	Quality and Outcomes Framework
RCM	Regional communications manager
RCT	Randomised controlled trials

R/M	Routine and manual
RPM	Regional performance manager
RTPM	Regional tobacco policy manager
SFIs	Standing Financial Instructions
SHA	Strategic health authority
SLA	Service Level Agreement
SPC	Summary of product characteristics
UKCTCS	UK Centre for Tobacco Control Studies
WCC	World Class Commissioning

Using this document

Please note that definitions for key terms can be found in the Definitions section in Annex D (see page 95), while highlighted words link to other areas of the document. The research on which this guidance is based is fully referenced throughout.

EXECUTIVE SUMMARY

The provision of high-quality NHS Stop Smoking Services is a high priority. They have already helped many people to stop smoking successfully and are a key part of tobacco control and health inequalities policies both at local and national levels.[1]

Evidence-based NHS stop smoking support is highly effective both in cost and clinical terms. It should therefore be seen in the same way as any other clinical service and offered to anyone who expresses an interest in stopping.

Targeting groups

As many smokers will need to make multiple attempts to quit before achieving long-term success, it is important that those who are motivated receive repeat interventions following a relapse. In line with National Institute for Health and Clinical Excellence (NICE) best practice recommendations, service providers should aim to treat a minimum of 5% of their local population of smokers in the course of a year.[2]

To work most effectively, however, it is necessary to focus on specific segments of the population – in particular, increasing access for smokers from routine and manual (R/M) groups, as quit rates are still lower for these groups than for those in higher socio-economic groups. Services also need to increase access for black and minority ethnic (BME) groups with high smoking rates (e.g. Bangladeshi men). Prisoners and those with mental illness also have very high levels of smoking and it is important that appropriate services are made available to these groups as well as pregnant smokers.

Primary and secondary care as well as mental health and prison care play a key role in referring people to NHS Stop Smoking Services, and referral opportunities need to be maximised.

Delivering services

Evidence-based guidelines[3] and NICE guidance should inform how services are delivered and the availability of smoking cessation aids (see Pharmacotherapy, page 49).

To optimise success, all recommended treatments will need to be offered as a first-line intervention.

1 Department of Health (2008) *Excellence in tobacco control: 10 high impact changes to achieve tobacco control*. DH. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084847

2 National Institute for Health and Clinical Excellence (2008) *Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities*. NICE. www.nice.org.uk/Guidance/PH10/NiceGuidance/pdf/English

3 West R, McNeill A and Raw M (2000) 'Smoking cessation guidelines for health professionals: an update'. *Thorax* 55(2):987–99

All GPs, pharmacists and dentists should be made aware of their local NHS Stop Smoking Service and its referral mechanisms.

Data and monitoring

The full and accurate completion of individual client data monitoring forms, and their timely submission to the service, is a condition for qualifying as an NHS Stop Smoking Service provider (see Monitoring NHS Stop Smoking Services, page 86).

In the amended quarterly return (from April 2008), services should now include treatment data detailing the type of intervention, setting, socio-economic group and free prescription status.

Four-week quit data is required in order to assess the cost-effectiveness of defined stop smoking interventions. This may not include information on people who have stopped smoking ('four-week quits') without interventions delivered by stop smoking advisers (see Definitions, page 98).

Maintaining standards

Commissioning is a key lever for meeting service requirements. Commissioners and providers will need to work together to achieve optimum outcomes using evidence-based interventions. They will need to focus jointly on increasing reach and access for smokers from target groups, improving data quality and ensuring that resources are allocated appropriately.

All stop smoking advisers need to receive specific training to carry out their role. Any training should conform to the standards set out by the Health Development Agency's (HDA's) training standards document or its updates.[4] To achieve best practice, all service delivery models should also conform to established quality principles (see page 22).

As part of the Government's commitment to modernise and improve treatment for smokers who wish to stop, a new NHS centre for smoking cessation and training will be set up in 2009/10. The centre will provide a number of key products and services, including 'gold standard', nationally accredited training programmes for stop smoking practitioners and best practice delivery models based on the latest research evidence.

This guidance, and the products to be developed by the new NHS centre, all reflect the drive for World Class Commissioning (WCC) specifications and contracts by primary care trusts (PCTs) (see World Class Commissioning, page 27).

4 Health Development Agency (2003) *Standard for training in smoking cessation treatments*. HDA. www.nice.org.uk/aboutnice/whoweare/aboutthehda/hdapublications/standard_for_training_in_smoking_cessation_treatments.jsp

INTRODUCTION

This document provides best practice guidance relevant to the provision of all NHS stop smoking interventions and sets out fundamental quality principles for the delivery of services which can be used to inform the development of local commissioning arrangements. It also includes full details of the data reporting requirements for NHS Stop Smoking Services. We therefore urge service commissioners and public health and PCT leads to note the changes and additions to this guidance and to refer to it in the course of their endeavours to provide high-quality services for smokers who want to stop.

Smoking is one of the most significant contributing factors to life expectancy, health inequalities and ill health, particularly cancer, coronary heart disease and respiratory disease (see Lung health and chronic obstructive pulmonary disease, page 45). Reducing smoking is therefore a key improvement area within the overarching health and well-being Public Service Agreement (PSA) area, strategic health authority (SHA) Local Delivery Plans, within the NHS Operating Framework and in Local Area Agreements (LAAs).

PSA SR07 states 'Tackle the underlying determinants of ill health and health inequalities by: reducing adult smoking rates to 21% or less by 2010, with a reduction in prevalence among routine and manual groups to 26% or less.'

Continued effort will be needed to ensure that there are sustained reductions in smoking prevalence (especially among smokers from routine and manual (R/M) groups). While the rate of progress against Public Service Agreement (PSA) targets for 2010 has been encouraging, there is no room for complacency – especially since evidence from other sources suggests that prevalence reductions stimulated by Smokefree legislation may, in part, be temporary. It is imperative that all those involved in tobacco control activity continue to press for further prevalence reductions, especially with regard to R/M groups.

Current smoking rates in England are 21% overall, and 26% for R/M groups.[5] Smoking prevalence is highest in deprived communities. Progress against the Public Service Agreement (PSA) target for routine and manual smokers (reduction from 33% in 2001 to 26% in 2010) has historically been slower relative to that of other population groups. A high level of intervention is vital to deliver effective, cross-social group reach on this, the biggest single public health issue. Reducing smoking prevalence in the Spearhead Group of local authorities (LAs) and the PCTs which map to them is also a key intervention to meet the health inequalities, life expectancy, infant mortality and all-age, all-cause mortality PSA targets, as well as the inequalities elements of the cardiovascular disease (CVD) and cancer PSA targets.

Health reform in England: update and commissioning framework[6] and the *Commissioning Framework for health and well-being*[7] set out the policy framework for commissioning within the wider context of the health reform programme (see Annex I). The commissioning framework signals a strategic re-orientation towards promoting health and well-being and investing now to reduce future ill health costs.

Current strategic policy objectives have been formulated to achieve the following (by or before the end of 2010):

1. **Modernise NHS Stop Smoking Services**: improve treatment effectiveness, performance management and access to effective treatment through NHS support services and helplines.
2. **Improve the effectiveness of pharmacotherapy** usage and develop the evidence base for a harm reduction strategy.
3. **Improve the evidence base** for smoking cessation work and intelligence on the efficacy of interventions.

To meet these goals, the Department of Health (DH) is funding a number of programmes designed to improve referral rates from key settings (primary and secondary care). It is committed to the development and delivery of nationally accredited and evidence-based training and professional registration for NHS stop smoking practitioners. DH is also funding a national support team (NST) to help areas improve the effectiveness of tobacco control interventions at a local level through partnerships. Related work is also planned, working with LAs and the Improvement and Development Agency (IDeA), to identify ways of reducing R/M smoking prevalence through wider tobacco control in community settings.

5 Office for National Statistics (2009) *Smoking and drinking among adults, 2007*. ONS. www.statistics.gov.uk/statbase/Product.asp?vlnk=5756
6 Department of Health (2006) *Health reform in England: update and commissioning framework*. DH. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4137226
7 Department of Health (2007) *Commissioning framework for health and well-being*. DH. www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_072604

2009/10 will also see the establishment of the new NHS Centre for Smoking Cessation and Training as part of the Government's commitment to modernise and improve treatment for smokers who wish to stop. The Centre will provide a range of products and services, including 'gold standard', nationally accredited training programmes for stop smoking practitioners and models of best practice for the delivery of NHS stop smoking interventions, based on the latest research evidence.

These guidelines

This updated guidance is not meant to pre-empt the training and best practice models that will be developed by the NHS Centre. It is intended for everyone involved in managing, commissioning or delivering NHS Stop Smoking Services and should be used to inform service planning until further notice.

It has been developed in collaboration with representatives from NSTs, SHAs, PCTs and the NHS Information Centre (IC) as well as academics from the field of smoking cessation. It supersedes all earlier DH smoking cessation guidelines.

This document therefore reflects the full range of NHS Stop Smoking Services now available in England and shows how they can be applied to priority population groups, such as R/M smokers (see page 61), smokers from black and minority ethnic (BME) groups (see page 66), smokers with mental health problems (see page 69) and pregnant smokers (see page 74), as well as prisoners who smoke (see page 78).

A key message is that **all** smokers should be advised to stop smoking and offered evidence-based support, regardless of whether they express a desire to stop. A second key message is that evidence-based NHS support to stop smoking is highly cost-effective and clinically effective and should **always** be offered to people who express an interest in stopping.

Note: to ensure that guidance remains up-to-date, this document will remain 'live' and will be revised as necessitated by further policy changes or research developments.

EVIDENCE RATING OF RECOMMENDATIONS

Every recommendation in the delivery section of this guidance has a rating to show the extent to which it is evidence-based. This has been done according to the New Zealand Guidelines Group (NZGG) system,[8] as adapted from the SIGN rating system, as follows.

A	The recommendation is supported by good (strong) evidence
B	The recommendation is supported by fair (reasonable) evidence, but there may be minimal inconsistency or uncertainty
C	The recommendation is supported by expert (published) opinion only
I	There is insufficient evidence to make a recommendation
✓	Good practice point (in the opinion of the guidance development group)

8 New Zealand Ministry of Health (2007) *New Zealand Smoking Cessation Guidelines*. Wellington: Ministry of Health

PART 1: COMMISSIONING

NHS Stop Smoking Services are now well established and are delivering substantial numbers of successful four-week quitters. The services provide around a quarter of all successful quits per annum and have been praised by the Healthcare Commission for the contribution they make to the national health inequalities agenda. They therefore remain a key element of the Government's overall tobacco control strategy.

The primary role of NHS Stop Smoking Services is to provide a high-quality clinical smoking cessation service to their local population. They should not be regarded as the main driver for reducing smoking prevalence, which is affected to a much greater degree by national policy and local tobacco control strategies. NHS Stop Smoking Services should sit within an overall tobacco control programme and should form a part of wider action to reduce local smoking prevalence.[9]

In the course of a year, services should aim to treat at least 5% of the local population of smokers, in line with best practice recommendations contained within National Institute for Health and Clinical Excellence (NICE) programme guidance for smoking cessation.[10] By supporting local smokers who want to stop they can help reduce health inequalities and have a significant long-term impact on local and national smoking prevalence.

To achieve their aims, services and types of intervention will need to be configured according to local needs. Understanding those needs is therefore vital, as is gauging the impact each type of service provision can have on reductions in prevalence.

9 Department of Health (2008) *Excellence in tobacco control: 10 High Impact Changes to achieve tobacco control*. DH. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084847

10 National Institute for Health and Clinical Excellence (2008) *Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities*. NICE. www.nice.org.uk/Guidance/PH10

Targeting services

The key to ensuring that services are aligned with the needs of the local population is data profiling. A great deal of information can be drawn from data sources such as the Office for National Statistics (ONS) mid-year population estimates, the Annual Population Survey, the Labour Force Survey and the 2001 Census. This includes population numbers, smoking prevalence, socio-economic group, deprivation, economic status, industry, occupation and ethnicity. Much of this data can also be obtained through the Neighbourhood Statistics website: www.neighbourhood.statistics.gov.uk/dissemination/.

Targeting priority groups

It should be noted, however, that routine and manual (R/M) smokers make up 44% of the overall smoking population. Targeting this group will need to be a priority for NHS Stop Smoking Services. Commissioners will need to monitor throughput and success rates, aiming for a minimum throughput of around 50% of local R/M smokers and maximising and sustaining potential quits by ensuring that the most effective and well-evidenced approaches are used.

Other groups that require proportionate targeting include black and minority ethnic (BME) communities and pregnant women, as well as people with mental health problems and prisoners (see pages 66–82).

Table 1: Distribution of R/M smokers by region

Region	R/M smokers (% of England total)	Prevalence of smoking among R/M group (%)
North East	6%	29%
North West	17%	28%
Yorks & Humber	13%	29%
East Midlands	8%	23%
West Midlands	15%	31%
East of England	10%	25%
London	10%	23%
South East	11%	22%
South West	10%	25%

Source: ONS 2009.[11]

11 Office for National Statistics (2009) *Smoking and drinking among adults, 2007*. ONS. www.statistics.gov.uk/statbase/Product.asp?vlnk=5756

Balancing reach and efficacy

Ideally, NHS Stop Smoking Services should combine interventions that are appropriate to the needs, preferences and diversity of their local smoking population, while being particularly mindful of reaching those with health and social inequality. Commissioners will need to balance the need for widely accessible services against the need for high efficacy rates. Some interventions, such as online or telephone support, reach high volumes of smokers, but may be less intensive and therefore less effective. Interventions such as closed groups (see page 36) are highly effective and should form part of the overall service delivery, but will need sustained, effective local promotion to ensure throughput

Efficacy and choice

Meeting the needs of an individual means understanding their lifestyle and personal preferences. It is therefore important to provide a choice of interventions. All options, however, need to be offered to smokers accompanied by supporting information regarding the relative chances of success of each intervention type (e.g. group, one-to-one or telephone support) at local and national levels.

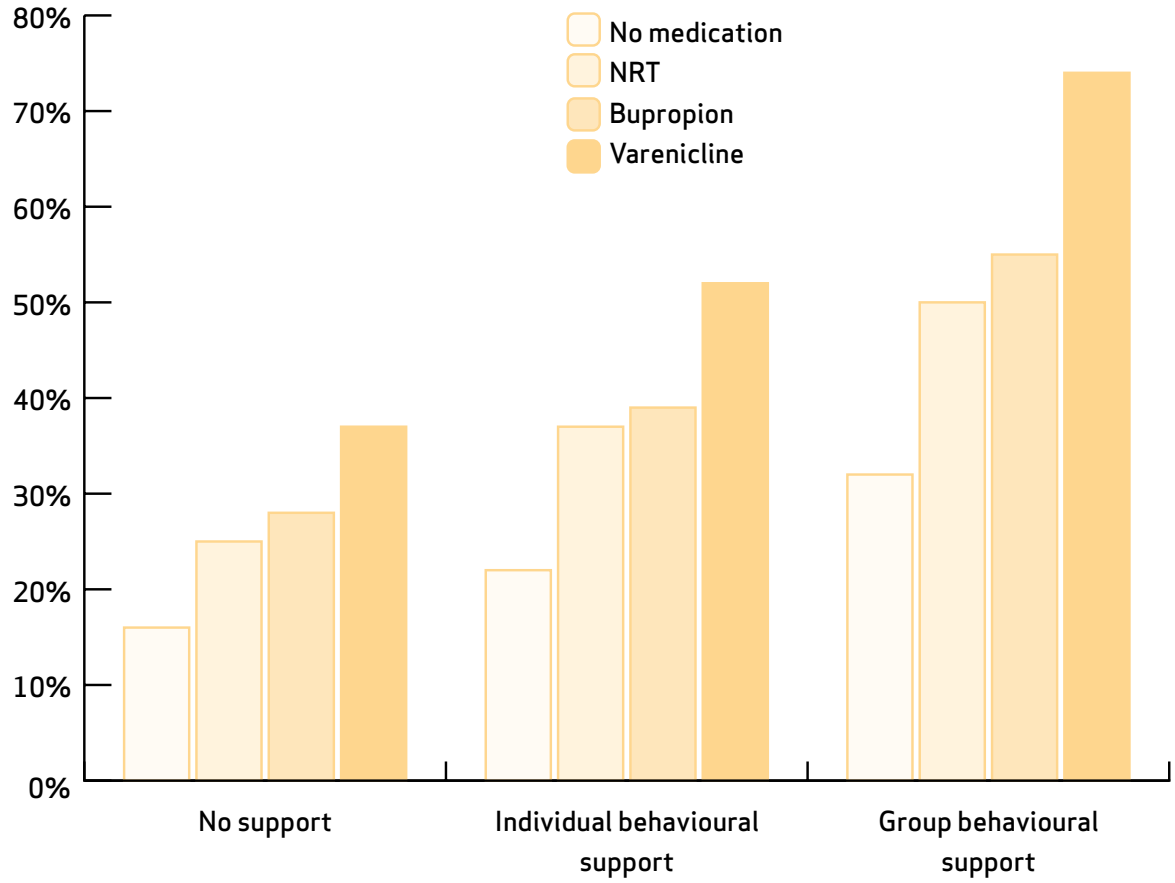
For example, since gaining NICE approval in 2007, Champix (varenicline) has proved to be a highly cost-effective treatment, resulting in average success rates of 61% at four weeks in the first and second quarters of 2008/09[12] (see page 57). Since all motivated quitters should be given the optimum chance of success in any given quit attempt, nicotine replacement therapy (NRT), Champix (varenicline) and Zyban (bupropion) should all be made widely available in combination with intensive behavioural support as first-line treatments (where clinically appropriate).

The new NHS Centre for Smoking Cessation and Training will be producing best practice models, illustrating the optimum mix of treatment delivery methods and settings. In the meantime, however, commissioners should seek to ensure that services are providing high-efficacy treatments to as many smokers as possible, while ensuring that those treatments are easy to access for all parts of the local smoking population.

12 NHS Information Centre (2009) *Statistics on NHS stop smoking services in England, April 2008 to September 2008 (Q2 – Quarterly report)*. www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/nhs-stop-smoking-services/statistics-on-nhs-stop-smoking-services-in-england-april-2008-to-september-2008-q2--quarterly-report

Table 2: Effectiveness of pharmacotherapy and support options

The relative impact of a variety of evidence-based stop smoking interventions and pharmacotherapies upon four-week quit rates.



Four-week quit rates	No medication	NRT	Bupropion	Varenicline
No support	16%	25%	28%	37%
Individual behavioural support	22%	37%	39%	52%
Group behavioural support	32%	50%	55%	74%

Source: *Cochrane Database of Systematic Reviews*[13]

13 Cahill K, Stead LF and Lancaster T (2008) 'Nicotine receptor partial agonists for smoking cessation'. *Cochrane Database of Systematic Reviews*, Issue 3. Art. No.: CD006103. DOI: 10.1002/14651858.CD006103.pub3.
Stead LF, Perera R and Lancaster T (2006) 'Telephone counselling for smoking cessation'. *Cochrane Database of Systematic Reviews*, Issue 3. Art. No.: CD002850. DOI: 10.1002/14651858.CD002850.pub2.
Stead LF, Perera R, Bullen C, Mant D and Lancaster T (2008) 'Nicotine replacement therapy for smoking cessation'. *Cochrane Database of Systematic Reviews*, Issue 1. Art. No.: CD000146. DOI: 10.1002/14651858.CD000156.pub3.
Stead LF and Lancaster T (2005) 'Group behaviour therapy programmes for smoking cessation'. *Cochrane Database of Systematic Reviews*, Issue 2. Art. No.: CD001007. DOI: 10.1002/14651858.CD001007.pub2.
Hughes JR, Stead LF and Lancaster T (2007) 'Antidepressants for smoking cessation'. *Cochane Database of Systematic Reviews*, Issue 1. Art. No.: CD000031. DOI: 10.1002/14651858.CD000031.pub3.

Table 3: Intervention success rates

Estimated success rate ranges for different intervention types.

Intervention type	Estimated four-week success rate range
One-to-one support	22%–52%[a]
Couple/family support	Insufficient evidence[b]
Closed group support	32%–74%[a]
Open (rolling) group support	Insufficient evidence[b]
Drop-in support	Insufficient evidence[b]
Telephone support	22%–51%[a]
Online support	28%–66%[c]

Notes:

a Indicates success range by intervention type from clients receiving no medication to those receiving NRT, bupropion or varenicline.

b Indicates availability of little or no published research evidence regarding the efficacy of these intervention types and therefore insufficient available data to estimate four-week success rates.

c Indicates the indicative four-week success rate from existing studies of online support. Evidence of success rates of online support combined with medication are not currently available.

Delivering interventions

Notwithstanding the wide range of stop smoking approaches, all interventions should:

- ☐ reinforce the motivation to quit and set a quit date
- ☐ inform client expectations regarding the structure and process of the intervention
- ☐ assess nicotine dependence and offer appropriate feedback
- ☐ provide information on the nature of tobacco withdrawal and advice on the management of withdrawal symptoms
- ☐ give comprehensive advice on appropriate pharmacotherapies, possible side effects and methods of access
- ☐ monitor pharmacotherapy use
- ☐ build a repertoire of coping strategies
- ☐ include regular carbon monoxide (CO) checks and give feedback on progress
- ☐ troubleshoot specific client problems
- ☐ CO-verify quit status four weeks from the quit date

- plan ongoing coping mechanisms, support and pharmacotherapy at the end of treatment
- assess client satisfaction with the intervention provided

MEASURING CLIENT SATISFACTION

In 2008, a pilot project was conducted to evaluate a tool for measuring levels of client satisfaction with NHS Stop Smoking Services.[14] The full report of this project can be found at www.scsrn.org/department_of_health_projects.html.

The validated tool can be found at Annex E (page 100) while details of a larger-scale evaluation that is currently under way can be found at the web address given above.

In recent years, the majority of NHS Stop Smoking Services have modified their treatment protocols, dramatically increasing the proportion of treatment delivered in healthcare settings such as primary care and in pharmacies. There has also been a sharp rise in the proportion of one-to-one interventions and a corresponding decline in the provision of closed group treatment (the model recommended in national guidance when the services were first set up 10 years ago). This trend is shown by the quarterly data submitted to the NHS Information Centre (IC) following the addition of the new data items from April 2008 (throughput and success rates by intervention type and setting). This new data allows us to map treatment delivery methods and settings across the NHS service network (see Table 4).

The results also show that closed group provision is significantly more effective, with an average success rate of 63% compared with 48% for one-to-one treatment.[15] The changes in delivery approaches have therefore led to an overall decline in treatment efficacy, which needs to be addressed at national, regional and local levels.

14 McEwen A, Arnoldi H, Bauld L, May S, Ferguson J and Stead M (2008). *Client Satisfaction Survey: Pilot Project Report*. Smoking Cessation Service Research Network

15 NHS Information Centre (2009) *Statistics on NHS stop smoking services in England, April 2008 to September 2008 (Q2 – Quarterly report)*. www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/nhs-stop-smoking-services/statistics-on-nhs-stop-smoking-services-in-england-april-2008-to-september-2008-q2--quarterly-report

Table 4: Stop smoking experimental statistics[a]

Number of smokers setting a quit date and successful quitters[b] by intervention type and setting, April to September 2008.

England	Numbers/percentages		
	Number setting a quit date	Number of successful quitters	Percentage who successfully quit
Intervention type			
Closed group	8,329	5,271	63
Telephone support	2,795	1,635	58
Couple/family	2,628	1,447	55
Open (rolling) group	13,696	7,214	53
One-to-one support	210,929	101,498	48
Drop-in	23,920	11,481	48
Other	8,190	4,085	50
Unknown	2,677	1,073	40
Total	273,164	133,704	49
Intervention setting			
Prison	4,083	2,348	58
Stop Smoking Services	79,324	41,702	53
Military base	1,434	755	53
Hospital ward	3,006	1,575	52
Primary care	128,364	60,952	47
Dental practice	286	133	47
Pharmacy	43,849	19,940	45
Other	9,634	4,863	50
Unknown	3,184	1,436	45
Total	273,164	133,704	49

Notes:

a The statistics in this table have been classified as **experimental statistics**.

b A client is counted as having successfully quit smoking at the four-week follow-up if they have not smoked at all two weeks after the quit date.

Source: adapted from NHS Information Centre[16]

16 NHS Information Centre (2009) *Statistics on NHS stop smoking services in England, April 2008 to September 2008 (Q2 – Quarterly report)*. www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/nhs-stop-smoking-services/statistics-on-nhs-stop-smoking-services-in-england-april-2008-to-september-2008-q2--quarterly-report

Establishing quitter smoking status

There are a number of well-established biochemical methods for establishing smoking status in individuals attempting to quit (see page 42). The most cost-effective and least invasive of these is the measurement of expired air CO. Since self-reported smoking status can be unreliable, CO validation rates are important markers of data quality.

The 2007 guidance update recommended that services should aim for a minimum CO validation rate of 85% (of all reported four-week quits). Although some services have made efforts to improve their rates in line with this advice, data from the first two quarters of 2008/09 indicates that, on average, services are achieving CO validation rates of around 67%.[17] There is therefore some way to go before achieving the recommended level.

Commissioners play a key role in ensuring that providers have the capacity and capability to comply with CO monitoring requirements (under core contracts and Service Level Agreements (SLAs)).

In turn, providers have responsibility for implementing and providing evidence of effective quality systems for CO monitoring.

Measuring success

Four-week quit smoking rates are the local measure to reflect smoking prevalence as set out in Tier 2 Vital Signs in the NHS Operating Framework. They are also a National Indicator (NI 123) in the Local Area Agreement (LAA) process. They provide a useful performance measure for NHS Stop Smoking Services and a means of tracking service performance against local operating plans.

The use of the four-week point as a measure of clinical outcome (stop smoking success) has been questioned, but if the quality of smoking status data at four weeks is good (and is supported by high rates of CO validation) then longer-term success rates can be calculated with a high degree of accuracy. This is because relapse rates for smoking are predictable and well documented in the research literature (see page 83).

Where resources allow, longer-term follow-up data can provide a further check of efficacy, especially for sub-populations or specific pilot projects. In general, however, following up service users over long periods of time can become very resource-intensive, as many of them will have changed their address or contact details. NHS Stop Smoking Services are therefore not required to supply this level of data – but they need to ensure that sufficient resources are in place to complete four-week follow-ups, as these provide essential monitoring data.

17 NHS Information Centre (2009) *Statistics on NHS stop smoking services in England, April 2008 to September 2008 (Q2 – Quarterly report)*. www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/nhs-stop-smoking-services/statistics-on-nhs-stop-smoking-services-in-england-april-2008-to-september-2008-q2--quarterly-report

NHS Stop Smoking Services provide around a quarter of all successful quits per annum but wider, comprehensive action on tobacco control will be required if we are to drive down smoking prevalence in England. This will require effective partnership action at national, regional and local levels. Local authorities (LAs) will have a key role to play and we will need a measure that is more representative of actual smoking prevalence rates (including R/M prevalence) in order to track progress. It should be possible to introduce a new prevalence-based indicator for wider tobacco control activity from 2011 when data from the Integrated Household Survey (IHS) becomes available.

Working with other service providers

Stop smoking service leads and commissioners need to ensure that SLAs or Local Enhanced Service (LES) contracts with service providers include clear criteria for delivery and reporting requirements (with deadlines for data return). All staff involved in this work should be trained, either by the service or in-house,[18] to provide stop smoking interventions. Service delivery in all settings will need to be spot-checked at regular intervals to ensure that the *intervention* being provided is of acceptable quality and duration. Providers who fail to return data within the prearranged deadlines should be made aware that payments will not be made for late data.

PRIMARY CARE SERVICES

Primary care is a key setting for stop smoking interventions and an important source of referrals to NHS Stop Smoking Services. Service leads will need to ensure that all local GPs and other healthcare professionals (HCPs) (e.g. practice nurses, district nurses, midwives and health visitors) are aware of the AAA model for the provision of brief advice and referral of smokers to local NHS Stop Smoking Services (see page 33). GPs should be made aware of all local service and referral options. It is not recommended that GP teams be paid for stop smoking activities or for the return of data monitoring forms to the stop smoking service, unless the work is being conducted outside normal working hours or by bank staff. Helping smokers to quit is a key part of the remit of all primary care staff, and payments are already made to practices for this activity under the Quality and Outcomes Framework (QOF).

While smoking cessation interventions in GP practices and pharmacies are in general less effective than interventions delivered by specialist staff, they remain a valuable resource and should continue to form part of the overall support offered. They provide clients with greater choice and flexibility, since they are often available in places and at times when specialist provision may be unavailable. Service users should be given a menu of options along with their typical efficacy rates, enabling them to make informed choices.

18 Health Development Agency (2003) *Standard for training in smoking cessation treatments*. HDA. www.nice.org.uk/aboutnice/whoweare/aboutthehda/hdapublications/standard_for_training_in_smoking_cessation_treatments.jsp

PHARMACIES

Pharmacies have a good track record of providing stop smoking services to the general public. Ideally placed to provide this service, they are based in the heart of communities and are accessible to people who may not access GPs. Hospital-based pharmacies can also play an important role in developing and delivering stop smoking services in acute settings.

Commissioners and service leads should be encouraged to commission services from pharmacies and should continue to work in partnership with them to develop high-quality stop smoking services that the general public can access easily. Pharmacy staff may need to be remunerated for providing such services, with commissioners determining the level of payment according to the time and duration of interventions given, as well as team inputs for data handling.

DENTISTS

Almost 60% of the adult UK population visit a dentist for regular check-ups, including a high proportion of people aged 25–35. Dentists also have regular contact with pregnant women and teenagers, who are important groups for referral. Dental teams are therefore well placed to offer brief advice and refer smokers to their local NHS Stop Smoking Service. Where appropriate they can provide in-house intensive stop smoking support.[19] Hospital-based dental teams can also help to develop stop smoking services in acute settings.

It is not recommended that dental teams be financially rewarded for referring smokers to local NHS Stop Smoking Services. Where they deliver in-house stop smoking support, however, dental teams should be paid fairly and appropriately for this.

MENTAL HEALTH SERVICES AND PRISONS

Given that up to 70% of people in mental health units smoke,[20] mental health services are an important source of referrals to stop smoking services. So too are prisons, where 80% of the population smoke.[21] Further support for stop smoking interventions in prisons, as well as in children's centres and workplaces, is currently being scoped.

Increasing stop smoking referrals

In contrast to other sectors of the NHS, stop smoking services are under considerable pressure to recruit smokers into treatment in order to meet challenging local targets. The seasonality of quitting behaviour by the general public can also create challenges as

19 Department of Health (2003) *Smokefree and smiling: helping dental patients to quit tobacco*. DH. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074970
20 Jochelson J and Majrowski B (2006) *Clearing the air: Debating smoke-free policies in psychiatric units*. King's Fund
21 Singleton N, Farrell M and Meltzer H (1999) *Substance misuse among prisoners in England and Wales*. Office for National Statistics

demand can be very high at some times of year (e.g. January and February) yet fall to very low levels at others (e.g. July and August).

One way of tackling this is to increase referral rates from a variety of healthcare and community settings. The daily routine of healthcare provision provides many opportunities for brief stop smoking interventions and referrals to NHS Stop Smoking Services. Taking these opportunities can help to offset seasonal fluctuations in demand, raising the number of quit attempts and, therefore, successful quits.

REFERRAL SYSTEMS

Formal systems that support referrals to NHS Stop Smoking Services are needed across the health and social care sector in order to increase the number of quit attempts that benefit from expert support. Primary care teams, for example, have a key role to play in raising the issue of smoking with their patients, endorsing the value of quitting and referring them to NHS Stop Smoking Services. A systematic approach to increasing primary care referral rates, called 'Stop Smoking Interventions in Primary Care: a systems based approach', has shown promise in some areas. Combining a tiered approach to stop smoking support with effective delivery systems within a practice, the system will be rolled out nationally by the Department of Health (DH) throughout 2009/10. This launch will include a series of regional training events for NHS Stop Smoking Services and the publication of support resources for use in local practices.

The types of available NHS support may vary from area to area but all local referral systems will need to focus on directing smokers to their local NHS Stop Smoking Service. Staff there should have the time and expertise to assess every smoker's level of nicotine dependence and provide comprehensive advice on available treatments and pharmacotherapy. To maximise the chances of success, assessment and comprehensive advice should ideally be delivered **before** smokers are booked onto a chosen course of treatment.

VASCULAR RISK ASSESSMENT

From 2009/10, PCTs can choose to implement a systematic programme of vascular risk assessment and management. Where offered, this will provide a tailored package of prevention measures based on an assessment of an individual's risk of heart disease, stroke, kidney disease and diabetes.[22] DH modelling work shows that offering these checks to everybody aged between 40 and 74, with recall every five years, will be both clinically beneficial and cost-effective. The programme also has the potential to reduce health inequalities. Where it is fully implemented, DH estimates that the number of referrals to smoking cessation services will double for the 40 to 74 age group. For a simple toolkit which enables primary care trusts (PCTs) to estimate the number of

22 See www.improvement.nhs.uk/vascularchecks/

interventions that will be generated by the checks, visit www.improvement.nhs.uk/vascularchecks.

NHS SMOKING HELPLINE

The national NHS Smoking Helpline (0800 169 0 169) and the Smokefree website (www.nhs.uk/smokefree) currently provide referrals to NHS Stop Smoking Services, mostly from smokers responding to national campaign activity.

Work is under way to improve the links between national and local systems, improving the smoker's 'customer journey' and ensuring that referrals are as timely and efficient as possible (e.g. facilitating direct booking into local assessment and treatment options). The linking of systems will enable longer-term follow-up to be carried out using national systems and resources.

There are two pilot projects currently under way, in the West Midlands and the South West. One involves a direct linkage between the NHS Smoking Helpline and the local services database; the other allows services to access referrals from the national helpline via an online tool. If the pilots are successful, the IT specifications will be circulated, enabling other PCTs to make similar connections.

The national NHS Smoking Helpline has also established a customer relationship management (CRM) programme which can track communication with respondents who want to maintain contact with the helpline (e.g. via telephone or mail). Quitters can thereby be supported beyond their initial enquiry. Some stop smoking services may already have similar programmes in place, but others should think about how they maintain contact with users who are not referred from the national helpline. For example, a system could be set up to re-engage with unsuccessful quitters, attracting them back to the service at a later date or offering an alternative treatment.

Getting the message across

DH has invested significantly in marketing and communications that target R/M smokers, reinforcing their motivation to quit and driving them into the most effective methods of doing so (i.e. NHS Stop Smoking Services). This strategy was founded on detailed research based on social marketing principles (including qualitative research with the target audience and a review of behaviour change literature). The year-round campaigns use the NHS and Smokefree brands which are being established as the recognised brands for NHS Stop Smoking Services in England.

In the same way, strategies for promoting local services should be based on local intelligence wherever possible. Integration with regional and national campaigns should enhance their effectiveness, so they should also be planned in co-operation with tobacco

control and communications colleagues from PCTs and LAs, as well as with regional tobacco control leads.

Integrating local service awareness initiatives with regional and national campaigns, and using nationally branded materials provided for local promotion, helps smokers identify with local support services and can thereby promote self-referrals. It avoids confusing smokers by bombarding them with conflicting messages from different sources, and also enables local services to capitalise on the significant impact of national multi-media campaigns, saving them resources and effort while doing so.

Imaginative use of customised national materials by services in a variety of local media and channels (e.g. local stakeholder networks that the national campaign cannot reach) will ensure that service promotion is effective.

Smokefree literature and other resources can be ordered from the Smokefree extranet (www.smokefree.nhs.uk/resources). This also includes templates for local use which are easy to customise, and information about the national campaigns.

Quality principles

FINANCIAL PRACTICE

Commissioners entering into SLAs with third party service providers need to guard against the possibility of fraudulent claims for reimbursement. They should therefore be aware of the following quality principles:

- When setting up SLAs with third party providers, procedures and data processing instructions (including deadlines for data submission) should be verified with providers both verbally and in writing. It should also be made clear that deviation from specifications laid out in the SLA is not permitted.
- Commissioners should refer to local NHS Standing Financial Instructions (SFIs) for guidance on procurement and contracting of services. In addition, commissioners should seek guidance from their local procurement team/expert to ensure they adopt a consistent approach to contracting arrangements.
- Third party providers should be required to keep all relevant records for a minimum of two years, to allow for possible auditing.
- SLAs and local enhanced service contracts should stipulate that providers may not subcontract service provision to other parties and that claims made on this basis will not be paid.
- To safeguard commissioners against the possibility of fraudulent payment claims, all claim forms submitted to the service by third party providers should include the following declaration, which should be signed and dated by the claimant:

'I claim payment for the stop smoking services that I have provided which are shown above. I confirm that the information given on this form is true and complete. I understand that if I provide false or misleading information I may be liable to prosecution or civil proceedings. I understand that the information on this form may be provided to the Counter Fraud and Security Management Service, a division of the NHS Business Services Authority for the purpose of verification of this claim and the preventing, detecting and investigation of fraud.'

- If the commissioner has reasonable grounds to suspect that fraud has been committed by other parties/providers of stop smoking services, then they should immediately refer details to their local counter-fraud specialist (LCFS), based at their local Health Body. Alternatively, they can report the matter in confidence to the NHS Fraud and Corruption Reporting Line on 0800 028 4060.

QUALITY PRINCIPLES FOR STOP SMOKING INTERVENTIONS

NICE programme guidance on smoking cessation recommends the following stop smoking interventions as being cost-effective:

- brief interventions (see page 33)
- individual behavioural counselling (see pages 36–37)
- group behaviour therapy (see pages 36–37)
- pharmacotherapies – NRT, Zyban (bupropion) and Champix (varenicline) (see pages 49–58)
- self-help materials
- telephone counselling and helplines (see pages 37–38)

Services will vary in the types of intervention they choose to provide and in their approaches to delivery. The quality of services should, of course, remain consistent and should be maintained by laying out a set of clear principles. The quality principles presented here have been developed in response to the Healthcare Commission's concerns regarding data quality and aim to improve consistency across the NHS Stop Smoking Service network. They are based on previous guidance, changes in the evidence base and the latest understanding of 'best practice':

- Interventions should have a clear structure and content, which is communicated to clients and to which clients must commit.
- All interventions should be multi-sessional with a total potential client contact time of at least 1.5 hours (from pre-quit preparation to four weeks after quitting). This will ensure effective monitoring, client compliance and ongoing access to medication.
- There should be a strong emphasis on verifying CO levels four weeks from the quit date. This should be carried out in at least 85% of cases.

- Interventions should offer weekly support for at least the first four weeks following the quit date. Appointments should be scheduled when clients are booked into treatment.
- All staff involved in delivery should have been trained to Health Development Agency (HDA) standards.[23]
- Stop smoking advisers should show empathy for their clients and adopt a motivational approach.
- Prior to treatment, clients should be informed of all available (evidence-based) treatment options both locally and nationally.
- Interventions should be efficiently managed with sufficient administrative support for general organisation, client contact processes and data handling. There should be sufficient administrative support to ensure that clients are contacted within a week of being made known to the NHS Stop Smoking Service.
- New, non-evidence-based delivery models (such as rolling groups or drop-ins) may be piloted on a small scale and should be carefully evaluated before being adopted as a significant part of the service.
- Staff delivering rolling groups or drop-ins should be trained to HDA standards and such interventions should be delivered or supervised by experienced specialists with sufficient expertise to support quitters at different stages of the quitting process simultaneously.
- Only methods recommended by NICE should be funded by PCTs.
- Interventions should be based on the current evidence base.
- Workplace interventions should follow principles laid down in NICE workplace guidance and should be free for employees.[24]

23 Health Development Agency (2003) *Standard for training in smoking cessation treatments*. HDA. www.nice.org.uk/aboutnice/whoweare/aboutthehda/hdapublications/standard_for_training_in_smoking_cessation_treatments.jsp

24 National Institute for Health and Clinical Excellence (2007) *Workplace interventions to promote smoking cessation*. NICE. www.nice.org.uk/Guidance/PH5

THE ROLES OF SERVICE PROVIDERS AND COMMISSIONERS

Service providers need to take responsibility for delivering treatment services stipulated by the contract. They need to ensure that all necessary data is collected and that data verification procedures are followed for each client. They are responsible for maintaining the quality of treatment delivered (in line with the quality principles set out in this guidance) and for ensuring that client data confidentiality is protected in line with agreed protocols. Service providers need to ensure that staff receive the support they need to carry out their roles and remain up to date with national guidance and research developments. Service providers should be prepared for possible audits of their operations at any time and should maintain detailed records of their activities for inspection.

Commissioners need to ensure that the services commissioned are adequately resourced, evidence-based, effective, accessible and appropriate to the needs of the local population. Given the highly dynamic nature of this subject area and the continued drive to develop new pharmacotherapies and treatment approaches, commissioners will need to ensure that they are up to date with national guidance and are enabling services to be developed according to contractual arrangements. Commissioners are responsible for ensuring that effective clinical governance systems are in place, safeguarding the quality of treatment and data collection processes. They will also be responsible for signing off quarterly data submissions and ensuring that robust procedures for checking exceptional data are adhered to.

Checklist for commissioners

1. Have you obtained local prevalence and current activity data on smoking populations? Does this include high-risk groups such as those in prison or with mental health problems, as well as other priority populations such as BME groups and pregnant women?
2. Are you clear about the scale of the challenge to meet the national 2010 targets (local, regional and national indicators), and is service take-up by R/M smokers proportional to your local smoking population?
3. Have you established the composition of your local R/M population and its service needs?
4. Have you considered whether your NHS Stop Smoking Service offers the optimum balance of high-efficacy treatment, reach and accessibility?

5. Does your NHS Stop Smoking Service achieve CO validation rates at the recommended minimum of 85% of reported quits? If not, what action have you planned to address this issue?
6. Does your NHS Stop Smoking Service budget include adequate provision for the supply and maintenance of the required equipment (e.g. CO monitors, tubes and calibration kits)?
7. Are all NICE-approved stop smoking medicines available as first-line treatments for smokers wanting to quit? If not, what plans are in place to address this issue?
8. Does your NHS Stop Smoking Service provide high-efficacy, evidence-based interventions (e.g. closed groups)? If not, what action have you planned to address this issue?
9. Are there formal systems in your area that support referrals to the NHS Stop Smoking Service from all key healthcare settings (i.e. primary care and secondary care as well as mental health and prison care)? Does your service offer training to these workforces on smoking cessation?
10. Does your NHS Stop Smoking Service benefit from a robust, integrated IT system that provides:
    - ☐ systems for prompt and accurate return of quarterly service data?
    - ☐ concordance with mandatory data requirements and the flexibility to update data fields when necessary?
    - ☐ the facility to manage client appointments efficiently and conduct detailed analyses of local performance?
11. Does the NHS Stop Smoking Service have a suitably qualified full-time co-ordinator?
12. Do you have a robust and routine clinical governance system to monitor service quality and facilitate independent audits?
13. Do all interventions offered comply with the quality principles?
14. Are all NHS Stop Smoking Service employees supported to attend regional and national training events and do they all have continuing professional development plans?
15. Is NHS Stop Smoking Service development informed by local intelligence, community engagement and customer evaluation involving different populations?
16. Are commissioners and service providers in regular communication with external sources of support (e.g. national support team, regional tobacco policy manager, regional performance leads, public health observatories, relevant academic departments and public health experts)?

17. Do you have systems in place for clinical governance, monitoring and quality assurance of third party service providers (e.g. pharmacies, GP practices, third sector and commercial providers)?
18. Is the core NHS Stop Smoking Service fully aware of all commissioning arrangements for stop smoking provision and of how it should be working with other local providers of stop smoking support? (In other words, are locally commissioned stop smoking services fully integrated?)
19. Is stop smoking support for key populations a part of other commissioned services (e.g. maternity and secondary care services)? Are there clear service agreements, lines of accountability and performance management arrangements in place to support delivery?
20. Do local service marketing and promotion use national Smokefree branding and campaign messaging, and are they integrated with regional and national marketing plans?

World Class Commissioning

World Class Commissioning (WCC) aims to improve outcomes and reduce health inequalities. A key part of this is the assurance system that holds PCTs to account and rewards their development. Strategic planning at a local level is central to the process, ensuring that PCTs respond to the needs of their local population by considering all views and prioritising accordingly. Strategic planning, supported by financial planning, will enable PCTs to set out their vision for delivery over the next five years – and help them deliver both better care and better value.

WORLD CLASS STOP SMOKING SERVICES

This updated guidance will be useful for PCTs that have selected smoking prevalence as a WCC priority. It will help them identify what quality smoking cessation services look like, enabling them to select services based on the best available evidence and plan realistically to improve their current services.

In essence, WCC consists of 11 commissioning competencies. These describe a full commissioning cycle, from strategic planning (including engagement and partnership working), to robust technical skills such as needs assessment, information analysis, market shaping, contracting and procurement. They depend on tight performance management and management of finances.

Developing strengths in all of these competencies will improve outcomes, reduce health inequalities and, ultimately, 'add life to years, and years to life' – and that means better care and better value.

THE 11 HABITS OF WORLD CLASS COMMISSIONERS

World class commissioners:

- ☐ lead the NHS locally
- ☐ work with community partners
- ☐ engage with patients and the public
- ☐ collaborate with clinicians
- ☐ manage knowledge and assess needs
- ☐ prioritise investment
- ☐ stimulate the market
- ☐ promote improvement and innovation
- ☐ secure procurement skills
- ☐ manage the local health system
- ☐ make sound financial investments

FIVE-YEAR PLANNING

In 2008, all 152 PCTs were charged with producing five-year plans outlining how they would deliver their local health priorities. PCTs have been issued with guidance to help them produce these plans. The guidance describes how important it is to understand the local context, including demographics, health needs and the provider landscape. The Joint Strategic Needs Assessment plays an essential part in this process.

To help PCTs draw up their plans, DH has made 10 benchmarking data packs available. These packs provide a wealth of PCT-level data, including local health needs, details of NHS finance and priority issues – for example, smoking prevalence, the number of quitters and smoking-related conditions in the area.[25]

PCT strategic plans will form a core part of the commissioning assurance system – a national framework launched to hold PCTs to account for their commissioning decisions. The assurance system is part of the broader work of the WCC programme that aims to implement a new form of commissioning throughout the NHS.

The ultimate aim of WCC is to improve health and reduce health inequalities. PCTs will achieve this by commissioning in a more strategic way and making the improvement of local health outcomes central to all commissioning decisions.

25 See www.ic.nhs.uk/pubs/healthylifestyles05

DEPARTMENT OF HEALTH VITAL SIGNS

DH Vital Signs set out a combination of interim targets and longer-term outcomes for improving care and reducing health inequalities. The assurance system has three elements: outcomes, competencies and governance. The outcomes element is based on the Vital Signs and asks PCTs to select up to 10 local outcomes that reflect the priorities of their population. While PCTs strive to meet all their mandatory Vital Signs, the assurance process sets priorities, focusing PCTs on the Vital Signs that are most critical to their local population. The assurance system reflects best practice in commissioning and supports the Vital Signs process.

WCC MILESTONES AND COMPETENCIES

The vision for WCC was launched in December 2007. The first phase of activity generated a great deal of interest and began the process of developing a new, strengthened form of commissioning. The assurance system was launched in June 2008 and encouraged PCTs to focus on strengthening their role in the commissioning process. Since then, PCTs have been preparing for the assurance system, undertaking self-assessments, receiving feedback surveys from partners and reviewing their own internal processes. They have also been undertaking robust needs assessments, setting priorities and drafting plans to meet the needs of their local population for the next five years. These are informed by partners, including local government, providers, patients, the public and clinicians, and are underpinned by five-year strategies that cover finance, organisational development operating procedures, setting out how the strategy will be delivered. Every PCT will have prepared a draft set of final plans by March 2009.

To help them become world class commissioners, PCTs can draw upon a range of resources that they can tailor to their local needs. Support material is being developed by strategic health authorities (SHAs), while DH has published a list of providers who can help PCTs strengthen their governance arrangements. Other national resources include a portal being developed by the NHS Institute, and the DH WCC website which has top tips for each of the WCC competencies.

Individual PCTs will be responsible for involving their directors of public health in the formation of the PCT's strategic plan. As part of the assurance process, PCT five-year plans will be submitted to SHAs and regional directors of public health, who will then have a chance to provide their own input.

ASSURANCE PROCESSES

The WCC assurance system does not replace or cut across the existing system of performance management between SHAs and PCTs. Instead of assessing the immediate delivery of interim targets, it takes a longer-term look at commissioning capabilities in all PCTs. The assurance process will improve commissioning year on year, with PCTs likely to

become world class commissioners as quickly as acute trusts became Foundation Trusts. This reflects the challenging nature of the system and the step changes it is seeking to achieve. To ensure that systems are aligned, DH is working closely with regulators, including the Care Quality Commission.

WORLD CLASS COMMISSIONING OUTCOMES, DEPARTMENT OF HEALTH TARGETS AND SMOKING METRICS

As part of the WCC commissioning assurance system, and to demonstrate skills in prioritising and strategic planning, all PCTs are required to choose up to ten local health outcomes that they will be assessed against as part of the assurance of commissioning capability.

This process does not cut across the performance role in delivering against the wider set of national targets and making progress against the indicators in the Vital Signs. All PCTs are still required to meet these commitments. The outcomes element of the commissioning assurance system assesses PCTs on their ability to reflect the strategic priorities of their partners and local populations and their own abilities to accept that there are prioritisation decisions to be made locally.

Two of these 10 local outcomes are nationally set (life expectancy and health inequality) and the others are for selection locally in line with the five-year strategic plan being developed by every PCT with its partners. To support PCTs in the selection of these local outcome measures, a national list has been produced based on the Vital Signs. Outcomes are central to WCC and the national list of outcomes for WCC focuses on the subset of the Vital Signs that best reflect outcome metrics.

There are two metrics within the WCC national list that focus on smoking:

- smoking quitters at four weeks – rate per 100,000 population aged 16 and over
- smoking during pregnancy – actual percentage of women known to be smokers at the time of delivery

Early informal feedback on the 10 local priorities that PCTs are choosing as part of WCC and including in their strategic plans suggests that smoking is featuring highly. This reflects the greater emphasis towards health prevention and promotion. The precise outcomes are not submitted to DH centrally and so feedback is informal at this stage.

PART 2: DELIVERING

Evidence has shown that a combination of behavioural support from a stop smoking adviser plus pharmacotherapy (see page 49) can increase a smoker's chances of stopping by up to four times.[26] Stop smoking support can be delivered in a number of ways and it is important that smokers are offered a range of support options so they can choose the type of intervention that is right for them. All interventions share common properties (such as behavioural support, structure and the offer of approved pharmacotherapy) and they all involve multiple sessions.

A client may change the type of support he or she uses during a quit attempt or they may choose a combination of interventions.

For the purpose of data capturing the intervention type is the one chosen at the point the client sets a quit date and consents to treatment.

The following pages contain pragmatic definitions of the intervention types described in the quarterly dataset. They are not meant to constrain practitioners but reflect current delivery methods and the language used to describe the services being delivered at local level. All figures quoted are from the NHS Information Centre (IC) Quarters 1 and 2 2008/09 experimental statistics. They can be accessed via the website: www.ic.nhs.uk.[27]

26 West R, McNeill A and Raw M (2000) 'Smoking cessation guidelines for health professionals: an update'. *Thorax*; 55(2):987–99

27 NHS Information Centre (2009) *Statistics on NHS stop smoking services in England, April 2008 to September 2008 (Q2 – Quarterly report)*. www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/nhs-stop-smoking-services/statistics-on-nhs-stop-smoking-services-in-england-april-2008-to-september-2008-q2--quarterly-report

EVIDENCE RATING OF RECOMMENDATIONS

Every recommendation in the delivery section of this guidance has a rating to show the extent to which it is evidence-based. This has been done according to the New Zealand Guidelines Group (NZGG) system,[28] as adapted from the SIGN rating system, as follows.

A	The recommendation is supported by good (strong) evidence
B	The recommendation is supported by fair (reasonable) evidence, but there may be minimal inconsistency or uncertainty
C	The recommendation is supported by expert (published) opinion only
I	There is insufficient evidence to make a recommendation
✓	Good practice point (in the opinion of the guidance development group)

Brief and very brief interventions

Evidence rating: A

There are very few healthcare professionals (HCPs) who do not treat conditions caused by or exacerbated by smoking. Helping these patients to stop smoking is often the most effective and cost-effective of all the interventions they receive. Despite this, however, rates of intervention by HCPs remain low.

Simple advice from a physician can have a small but significant effect on smoking cessation.[29] Advice and/or counselling given by nurses also significantly increase the likelihood of quitting.[30]

GUIDANCE FOR HCPS

The USA, England, and New Zealand have all recently published guidance on brief interventions. These are aimed at motivating smokers to quit and support them during the attempt. Current National Institute for Health and Clinical Excellence (NICE) guidance describes these interventions as lasting 5 to 10 minutes. However, in the UK, appointments with a hospital consultant typically last 15 to 20 minutes, while those with a GP last 10. In such a context, it is not possible to spend 5 to 10 minutes discussing smoking when this is not the primary focus of the consultation.

28 New Zealand Ministry of Health (2007) *New Zealand Smoking Cessation Guidelines*. Wellington: Ministry of Health
29 Lancaster T and Stead L (2004) 'Physician advice for smoking cessation'. *Cochrane Database Systematic Reviews* 2004(4):CD000165
30 Hill Rice V and Stead LF (2008) *Nursing interventions for smoking cessation*. The Cochrane Library

Since giving stop smoking advice need only take a few minutes, all HCPs should be encouraged to deliver very brief or brief interventions as time allows. However, this approach needs to be sustained and systematic.

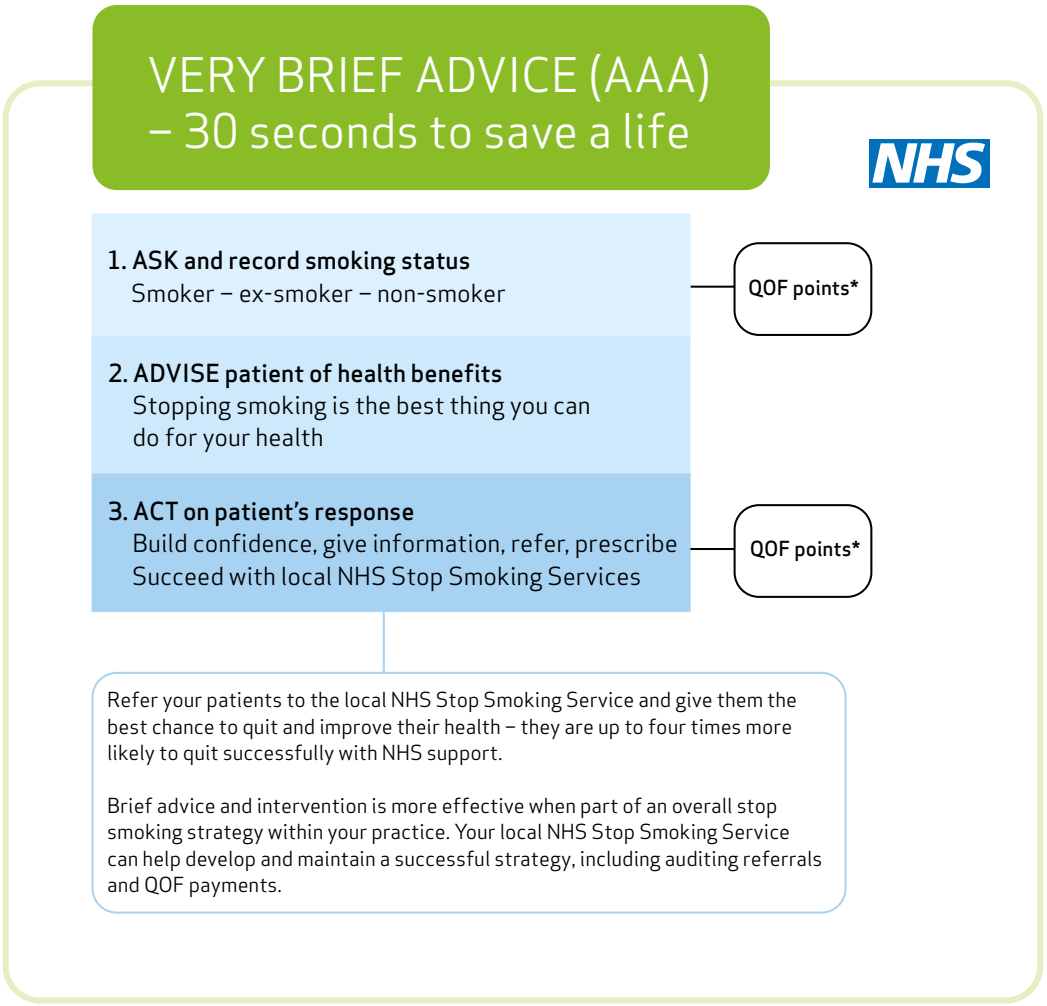
THE ROLE OF NHS STOP SMOKING SERVICES

There are not as many referrals to NHS Stop Smoking Services from primary care and other healthcare settings as there could be. To maximise the potential of this pathway, the Department of Health (DH) has developed 'Stop Smoking Interventions in Primary Care – a systems based approach'.

This short, practical guide helps NHS Stop Smoking Services establish efficient and effective systems for delivery of stop smoking support in primary healthcare settings. Key elements of the approach include:

- **Tiered stop smoking support** that establishes several levels of intervention. For example: 30-second very brief confidence-boosting advice for all smokers and referral to NHS Stop Smoking Services (see the diagram on page 35); more detailed intervention if time; and intensive support for highly motivated patients or those at high risk of developing smoking-related diseases.
- **A 10-part supportive delivery system** that offers high-quality stop smoking support to patients who attend in a practice setting.
- **A supportive practice environment** with friendly advice and promotional materials to help patients to stop smoking, and where Smokefree is the norm.
- **Helpful checklists and templates** to assess current systems, set an agenda for change and reward performance.

VERY BRIEF ADVICE – 30 SECONDS TO SAVE A LIFE



Behavioural support

Evidence rating: **A**

Behavioural support consists of advice, discussion and exercises provided face-to-face (individually or in groups). It can also be delivered by telephone. It aims to make a quit attempt successful by:

- ☐ helping clients escape from or cope with urges to smoke and withdrawal symptoms
- ☐ maximising the motivation to remain abstinent and achieve the goal of permanent cessation
- ☐ boosting self-confidence
- ☐ maximising self-control
- ☐ optimising use of pharmacotherapy

Intervention types

ONE-TO-ONE SUPPORT

Evidence rating: A
Estimated success rate range: 22% – 52%

This is an intervention between a single stop smoking adviser and a single smoker, at a specified time and place. It is usually delivered face-to-face.

The average self-reported quit rate in England for one-to-one, face-to-face support is 48% (n = 101,498), contributing 75.9% of the total number of successful self-reported four-week quitters in Quarters 1 and 2 2008/09.

COUPLE/FAMILY SUPPORT

Evidence rating: I

This is usually a face-to-face intervention between a stop smoking adviser, a smoker and up to a maximum of six family members or friends.

The average self-reported quit rate in England for couple and family support is 55% (n = 1,447), contributing 1% of the total number of successful self-reported four-week quitters in Quarters 1 and 2 2008/09.

CLOSED GROUP SUPPORT

Evidence rating: A
Estimated success rate range: 32% – 74%

A face-to-face intervention facilitated by a stop smoking adviser/s, with a number of smokers at a specified time and place. For example, a group may be held once a week, over a specific number of weeks, e.g. every Tuesday evening from 7.00pm to 8.00pm for six to seven weeks (see Quality principles, page 22 for minimum recommended client contact time). To account for diminishing client returns, a minimum of eight members is recommended.

The average self-reported quit rate in England for closed group support is 63% (n = 5,271), contributing 3.9% of the total number of successful self-reported four-week quitters in Quarters 1 and 2 2008/09.

OPEN (ROLLING) GROUP SUPPORT

Evidence rating: I

A face-to-face intervention facilitated by a stop smoking adviser/s, with a number of smokers at a specified time and place.

The average self-reported quit rate in England for open (rolling) group support is 53% (n = 7,214), contributing 5.4% of the total number of successful self-reported four-week quitters in Quarters 1 and 2 2008/09.

DROP-IN SUPPORT

Evidence rating: I

Face-to-face intervention provided at a specified venue or selection of venues at an unallocated time (although it could be a specified time slot, e.g. between 10.00am and 12.00pm). The service is provided by an individual stop smoking adviser with an individual smoker within the wider confines of an open access service.

Once the smoker has set a quit date and consents to treatment it is important that they are offered and encouraged to receive weekly support sessions for behavioural support, carbon monoxide (CO) monitoring and to check compliance with medication. While venues and appointment times can be flexible, the client must be advised to attend regularly to get the maximum benefit.

The average self-reported quit rate in England for drop-in support is 48% (n = 11,481), contributing 8.6% of the total number of successful self-reported four-week quitters in Quarters 1 and 2 2008/09.

TELEPHONE SUPPORT

There are a number of varieties of telephone support, including support that is proactive, reactive and text-based.

Proactive telephone support

Evidence rating: A
Estimated success rate range: 22% – 51%

This intervention should be delivered by stop smoking advisers and follow the same specification as one-to-one support. It should begin and end with a face-to-face session for CO validation and access to stop smoking pharmacotherapy on prescription should be available throughout the treatment episode.

The average self-reported quit rate in England for telephone support is 58% (n = 1,635), contributing 1.2% of the total number of successful self-reported four-week quitters in Quarters 1 and 2 2008/09.

All proactive telephone interventions should have a total potential contact time with the client of a **minimum** of 1.5 hours duration (from pre-quit preparation to the four-week post-quit period). This is to ensure regular monitoring, client compliance and continual access to pharmacotherapy. A minimum of 10 interventions in a 12-week period is

recommended[31] with a minimum of 10 minutes per intervention, apart from the first session, which will need to be longer to allow for assessment and planning.

Reactive telephone support

Evidence rating: B

Ongoing support following the four-week quit date may be provided over the telephone as part of a relapse prevention strategy. Only stop smoking advisers should deliver this intervention.

Text support

Evidence rating: I

There is currently insufficient evidence to demonstrate the efficacy of text support as the main intervention type. However, text may prove useful as part of a wider support programme or as a way of recruiting smokers to the service, reminding them of appointment times or providing ongoing reactive support.

NHS SMOKING HELPLINE TRIAL

DH is funding research to find out whether more people could achieve a smoke-free life if intensive support and a supply of free nicotine replacement products were offered through the NHS Smoking Helpline.

Called the Proactive or Reactive Telephone Smoking Cessation Support (PORTSSS) trial, the 18-month study involves academics at Nottingham, Bath, Glasgow and UCL universities and is due to begin in early 2009. The trial will look at whether the telephone helpline's success-rate could be improved by using scheduled calls to deliver support similar to that provided in face-to-face interventions and by mailing participants vouchers for nicotine patches.

31 Zhu SH, Anderson CM, Tedeschi GJ, Rosbrook B, Johnson CE, Byrd M et al. (2002) 'Evidence of Real-World Effectiveness of a Telephone Quitline for Smokers.' *New England Journal of Medicine* 347(14):1087–93

ONLINE SUPPORT

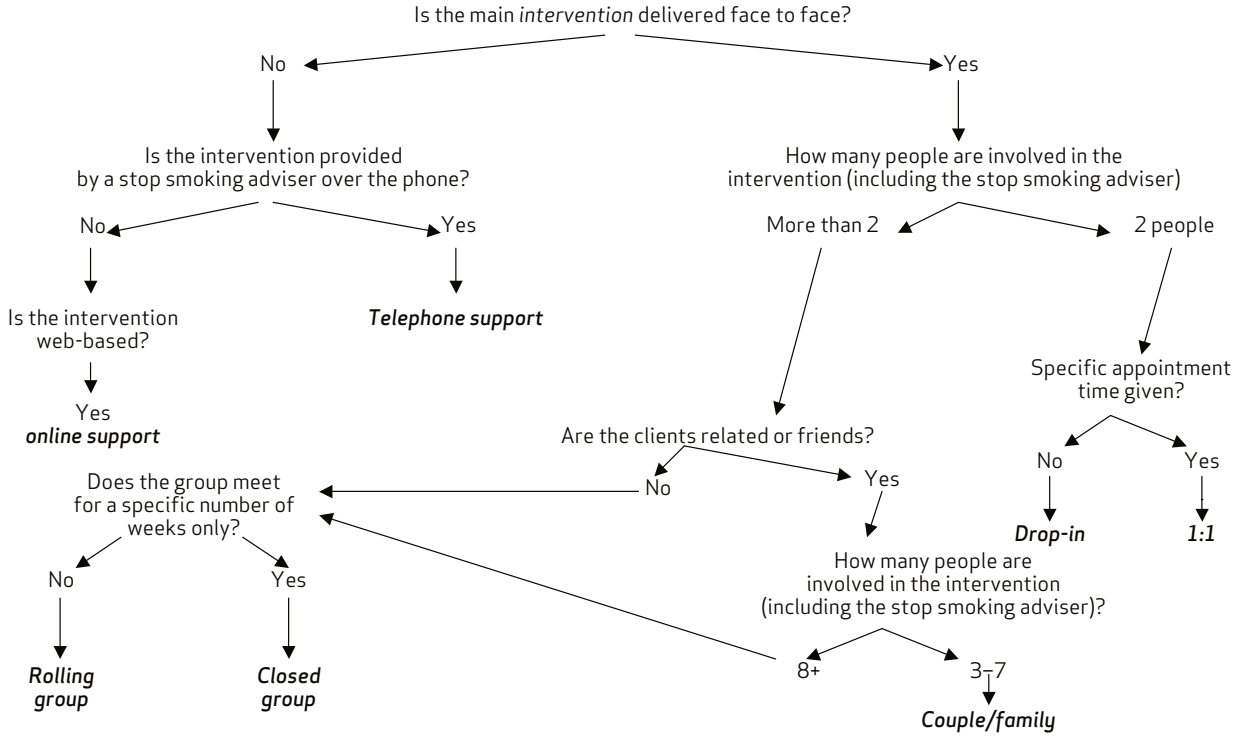
Evidence rating: **B**
Estimated success rate range: 28% – 66%

A rapid review of the evidence in this area concluded that online support for smoking cessation can be acceptable to users and is of superior efficacy to other wide-reach interventions and of similar efficacy to face-to-face interventions.[32]

However, more research is needed to determine how effective purpose-built, interactive, web-based stop smoking programmes are compared with websites that present simple advice on quitting smoking.

Wherever possible, providers of online smoking cessation interventions need to replicate standard outcome measures. This would mean developing innovative ways of biochemically verifying self-reported abstinence at the four-week mark.

INTERVENTION PATHWAYS



32 Shahab L and McEwen A (2008) *On-line support for smoking cessation: a systematic review of the literature.* Smoking Cessation Service Research Network

Assessing nicotine dependence

QUANTITATIVE APPROACH

Evidence rating: A

Tailoring stop smoking support for an individual starts with assessing their dependence on nicotine as this will have a bearing on the severity of the withdrawal symptoms they may experience, and therefore the intensity of support they require. It may also be used to indicate the most appropriate medication. The Fagerström test for nicotine dependence (FTND)[33] provides a quantitive measure and is the most widely used. It consists of six questions. The higher a client scores, the greater their nicotine dependency.

THE FAGERSTRÖM TEST FOR NICOTINE DEPENDENCE

1. How soon after you wake up do you smoke your first cigarette?

- ☐ After 60 minutes (0)
- ☐ 31–60 minutes (1)
- ☐ 6–30 minutes (2)
- ☐ Within 5 minutes (3)

2. Do you find it difficult to refrain from smoking in places where it is forbidden?

- ☐ No (0)
- ☐ Yes (1)

3. Which cigarette would you hate most to give up?

- ☐ The first in the morning (1)
- ☐ Any other (0)

4. How many cigarettes per day do you smoke?

- ☐ 10 or less (0)
- ☐ 11–20 (1)
- ☐ 21–30 (2)
- ☐ 31 or more (3)

5. Do you smoke more frequently during the first hours after awakening than during the rest of the day?

- ☐ No (0)
- ☐ Yes (1)

6. Do you smoke even if you are so ill that you are in bed most of the day?

- ☐ No (0)
- ☐ Yes (1)

Your score was:

Your level of dependence on nicotine is:

0–2 = very low dependence
3–4 = low dependence
5 = medium dependence
6–7 = high dependence
8–10 = very high dependence

33 Heatherton TF, Kozlowski LT, Frecker RC and Fagerström KO (1991) 'The Fagerstrom Test for Nicotine Dependence: A revision of the Fagerström Tolerance Questionnaire'. *British Journal of Addictions* 86:1119–27

HEAVINESS OF SMOKING INDEX

The two most important indicators of dependence, however, are considered to be: 'How soon after you wake do you smoke your first cigarette?' and 'How many cigarettes per day do you smoke?' It is therefore deemed adequate to use just these two questions as a shortened version of the FTND.

SHORTENED FTND

1. How soon after you wake do you smoke your first cigarette? (circle one response)		2. How many cigarettes per day do you usually smoke?	
Within 5 minutes	3	10 or less	0
6–30 minutes	2	11–20	1
31–60 minutes	1	21–30	2
After 60 minutes	0	31 or more	3

Cigarette consumption alone is not a good indicator of dependence, as it does not take into account the different ways people smoke their cigarettes. This may be particularly true for smokers who cut down the number they smoke but continue to get the same amount of nicotine from their reduced number of cigarettes by taking deeper and more frequent puffs, smoking more of each cigarette or blocking the vent holes.

OBJECTIVE APPROACH

Objective biochemical validation methods such as cotinine assessment can also be used to assess nicotine dependency by measuring the quantity of nicotine metabolites present. CO testing measures smoke intake and provides an immediate and cheaper alternative to cotinine testing (see page 42).

Biochemical markers

There are a number of well-established biochemical methods for establishing smoking status in individuals attempting to quit. The most cost-effective and least invasive of these is to measure the amount of CO in expired air.

CARBON MONOXIDE

Evidence rating: A

As self-reported smoking status can be unreliable, CO verification rates are an important marker of data quality. CO testing should be carried out on all adult smokers, wherever possible, to provide both a baseline (pre-quit) level and a four-week validation (post-quit) level. CO testing is quick to carry out, non-invasive and provides a cost-effective means of validating the smoking status of a significant number of clients.

To achieve as accurate a reading as possible, clients should be asked to hold their breath for 20 seconds (15 seconds minimum) before blowing into the CO monitor.

Some clients may not be able to physically complete CO testing due to the inability to hold their breath for 15 or more seconds. It is expected that a minimum of 85% of self-reported four-week quitters undertake expired carbon monoxide validation. Quarters 1 and 2 data from 2008/09 indicates that on average services are achieving CO validation rates of around 67%, so there is some way to go towards achieving recommended levels.[34]

The proportion of CO-verified clients can be calculated as follows:

$$\frac{\text{Number of treated smokers who self-report continuous abstinence from smoking from day 14 to the four-week follow-up point, and who have a CO reading of less than 10ppm}}{\text{All treated smokers}}$$

34 NHS Information Centre (2009) *Statistics on NHS stop smoking services in England, April 2008 to September 2008 (Q2 – Quarterly report)*. www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/nhs-stop-smoking-services/statistics-on-nhs-stop-smoking-services-in-england-april-2008-to-september-2008-q2--quarterly-report

Monitoring CO levels effectively

A recent survey of CO verification within NHS Stop Smoking Services showed that provision varies greatly.[35] As a result, it made the following recommendations:

- All stop smoking advisers need to have access to a CO monitor at every consultation. This should be supplied and properly maintained by the NHS Stop Smoking Service. Systems should be in place to ensure that CO monitors are calibrated according to the manufacturer's instructions.
- Stop smoking service training and documentation should stress the different uses of CO measurement at different time points, and emphasise the importance of verifying levels at the four-week post-quit point.
- Stop smoking services should have a written protocol for CO monitoring. This protocol should emphasise the importance of obtaining CO verification of self-reports as a part of follow-up procedures. There will also need to be a written protocol detailing infection control and management issues. The protocol should clearly state when monitors need calibrating, who should do it and how it should be done.
- Payment should only be made to intermediate advisers under a Local Enhanced Service (LES) if a full monitoring form (see Annex H) is completed and submitted to the stop smoking service. The stipulation that follow-up at four weeks is to be conducted with all self-reported quitters should be written into the LES agreement. If clients do not attend their appointment, they should be followed up by telephone, text or email (three times at different times of day) and, importantly, asked and encouraged to attend for CO-verification.
- Regional variations need to be addressed by ensuring that the regional tobacco control team monitors the data on CO verification from NHS Stop Smoking Services within its region and attends to low-performing services.

35 May S and McEwen A (2008) *NHS Stop Smoking Service CO-verification project*. Smoking Cessation Service Research Network

SAMPLE CO MONITOR PROTOCOL (INFECTION CONTROL)

Cardboard tubes

Single-use only, change for every patient/client. Ask the patient to put their own tube into machine and remove after use.

Plastic adaptor/T-piece

The adaptor contains a one-way valve that prevents inhalation from the monitor.

Changing adaptors depends on manufacturers' guidance:

Micromedical: the adaptor should be discarded and replaced every six months

Bedfont (Pico): the adaptor should be discarded and replaced monthly

BMC-2000: adaptor should be changed quarterly, unless usage is heavy, in which case change monthly

Usage guidance

Less than 50 uses per month: change quarterly

Between 51–200 uses per month: change bi-monthly

More than 200 uses per month: change monthly.

Contact your nearest stop smoking service office for supplies of adaptors/T-pieces.

Cleaning

The monitors should be wiped down using non-alcohol wipes, ideally at the end of every session.

Calibrating

All monitors should be calibrated every six months. Contact your nearest stop smoking service office to arrange calibration.

Stop Smoking Service offices

(Insert service details)

Adapted with kind permission from guidance produced by NHS County Durham and NHS Darlington

Carbon monoxide poisoning

A client may self-report that they are not smoking but, on testing, exhibit abnormally high expired CO levels. In such cases, they should be given advice about possible CO poisoning.

Health and Safety Executive (HSE) research from 2006[36] suggested that low-level chronic CO poisoning is a potential issue, with 8% living with dangerous levels of CO (CO is thought to kill 50 people each year and injure about 200).

The most common symptoms of mild CO poisoning are:

- headache
- feeling sick (nausea) and dizziness
- feeling tired and confused
- vomiting and abdominal pain

The symptoms of CO poisoning can resemble those of food poisoning and the flu. However, unlike flu, CO poisoning does not cause a high temperature.

Expired breath CO monitors have been validated to detect oxyhaemoglobin levels in non-smokers, and can therefore be used to identify items other than validation of smoking status.[37, 38]

All clients who have CO readings higher than 10ppm despite stopping smoking can be asked to call the free HSE Gas Safety advice line on 0800 300 363 for advice.

LUNG HEALTH AND CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Chronic obstructive pulmonary disease (COPD) is a term used to describe a number of conditions including chronic bronchitis, chronic airways obstruction and emphysema. COPD leads to inflammation and damaged airways in the lungs, causing them to become narrower and making it harder for air to get in and out of the lungs.

The most common cause of COPD is smoking. Occupational factors, such as coal dust, and some inherited problems can also cause COPD. Pollution as a factor causing COPD is currently under investigation.

If people do smoke then stopping is the single most effective, and cost-effective, way of reducing the risk of getting COPD. Stopping smoking can prevent or delay the

36 Health and Safety Executive (2006) *Gas Safety Review*. HSE
37 Stewart RD, Steward RS, Stamm W et al. (1976) 'Rapid estimation of carboxyhemoglobin levels in fire fighters'. *JAMA* 235:390–2
38 Kurt TL, Anderson RJ and Reed WG (1990) 'Rapid estimation of carboxyhemoglobin by breath sampling in an emergency setting'. *Vet Hum Toxicol* 32:227–9

development of airflow limitation, or reduce its progression,[39] and can have a substantial effect on subsequent mortality.[40]

Given the prevalence data on COPD in smoking populations, between 25 and 40% of the 300,000 people who access NHS Stop Smoking Services already have early COPD. However, the current system does not require a brief forced expiration screen/lung age measure to be taken. DH's national COPD Clinical Strategy requires a more effective way of identifying people with COPD early – and up to 130,000 of the unidentified 2 million people with COPD every year could be found using current NHS Stop Smoking Services. This represents a cost-effective use of existing resources and could save the development of additional new processes.

Addressing COPD during treatment

Since most smokers are not aware of the symptoms of COPD, it is recommended that all NHS Stop Smoking Service clients are informed of the following:

a) that 80% of COPD is caused by smoking

b) the key symptoms:

- chronic cough
- breathlessness
- production of spit or sputum after a coughing fit

c) the best options for advice/assessment if they have symptoms and are concerned

All clients should undertake a lung age measurement (assuming appropriate resources are available) and this should be communicated to the patient (see Lung function/ spirometry, page 47).

Abnormal or poor results should be referred to the client's GP for further diagnostic testing.

Good signposting between the stop smoking service and primary care or locally agreed referral points should be developed and maintained.

COPD Clinical Strategy

The forthcoming COPD Clinical Strategy is expected in May 2009 and contains the following markers of good practice that relate to stop smoking services, which should be noted:

39 Anthonisen NR, Connett JE, Kiley JP, Altose MD, Bailey WC, Buist AS et al. (1994) 'Effects of smoking intervention and the use of an inhaled anticholinergic bronchodilator on the rate of decline of FEV1'. The Lung Health Study, *JAMA* 272(19):1497–505

40 Anthonisen NR, Skeans MA, Wise RA, Manfreda J, Kanner RE, Connett JE et al. (2005) 'The effects of a Smoking Cessation Intervention on 14.5-Year Mortality: A Randomized Clinical Trial'. *Ann Intern Med* 142(4):233–9

- ☐ People, including HCPs, are aware that smoking is a major cause of COPD and that referral to evidence-based NHS support greatly enhances quit rates. Local public health campaigns, developed with input from smokers and ex-smokers, can therefore ensure that everyone knows how to access NHS Stop Smoking Services.
- ☐ There is growing recognition, particularly among HCPs, that tobacco dependency is a disease from which recovery is possible, and there is a need for ongoing support offered in a non-judgemental way.
- ☐ NHS Stop Smoking Services are commissioned that are responsive and appropriate to individuals' needs and provide ongoing access to help people to stop smoking and to remain abstinent. This means that a stop smoking intervention is offered at every healthcare contact, regardless of the time since the last quit attempt, and all smokers have access to nicotine replacement therapy (NRT) and other stop smoking medicines (see Pharmacotherapy, page 49).

LUNG FUNCTION/SPIROMETRY

Lung function and lung age measures provide biomedical feedback for smokers and are increasingly used to recruit smokers into stop smoking services and improve quit rates. A spirometer measures the volume of air expelled in the first second of a forced expiration, most commonly expressed as FEV1. Applying the FEV1 result to an individual gives them a 'lung age'.

CALCULATING LUNG AGE

Formula for measuring an individual's lung age.[41]

Men

Lung age = 2.87 x height (in inches) – (31.25 x observed FEV1 (litres)) –39.375

Women

Lung age = 3.56 x height (in inches) – (40 x observed FEV1 (litres)) –77.28

INCREASING QUIT RATES THROUGH LUNG FUNCTION/SPIROMETRY

Evidence rating: I

A Cochrane review concludes that there is a lack of evidence to support these approaches as methods for increasing quit rates. Despite the lack of data and the heterogeneity of the trials, the authors concluded that: 'Current evidence of lower quality does not

41 Morris JF and Temple W (1985) 'Spirometric "lung age" estimation for motivating smoking cessation'. *Prev Med* 14:655–62

however support the hypothesis that biomedical risk assessment increases smoking cessation in comparison with standard treatment'.[42]

None of these studies included identification and explanation of an individual's 'lung age'. A recent study of lung age calculations and the provision of this information to smokers showed no statistically significant impact upon recruitment to stop smoking services, but it did show an impact upon individual cessation activity. More research in this area is needed.

COTININE

Evidence rating: A

Cotinine is a metabolite of nicotine that can be detected in the blood, urine or saliva. CO monitoring is currently the most cost-effective method of validating four-week quits, due to the relatively high cost of other biochemical monitoring methods. For specific projects or groups such as pregnant women, however, using either urinary or salivary cotinine samples may be an appropriate validation method as the results will be more accurate and consistent over time. Further information on this can be sought from the UK Centre for Tobacco Control Studies (UKCTCS): www.ukctcs.org.

42 Bize R, Burnand B, Mueller Y and Cornuz J (2005) 'Biomedical risk assessment as an aid for smoking cessation'. *Cochrane Database of Systematic Reviews*, Issue 4. Art. No.: CD004705. DOI: 10.1002/14651858.CD004705.pub2

Pharmacotherapy

Combining behavioural support with pharmacotherapy increases a smoker's chances of successfully stopping by up to four times.[43] The only stop smoking medications currently approved by NICE are: NRT, bupropion (Zyban) and varenicline (Champix).

Primary care trust (PCT) leads and local prescribing committees should note that medicines recommended by NICE are extremely cost-effective and that cost-effectiveness studies are published on the NICE website. The numbers needed to treat (NNTs) in order to achieve a long-term quitter compare very favourably with other interventions routinely delivered in primary care.

Current experimental statistics from the NHS Stop Smoking Services indicate that varenicline was the most successful smoking cessation aid between April and September 2008. Of those who used varenicline 61% successfully quit, compared with 50% who received bupropion only and 46% who received NRT only.[44]

All approved stop smoking pharmacotherapies should ideally be offered on prescription to any smoker who wants to make a quit attempt. They should remain available for at least the duration recommended by the product specification (see Table 5 on page 51) and patients should be able to access approved stop smoking medicines simply and easily. Many areas use patient group directions (PGDs) and/or voucher systems to make this possible.

43 West R, McNeill A, Raw M (2000) 'Smoking cessation guidelines for health professionals: an update.' *Thorax* 55(2):987–99

44 NHS Information Centre (2009) *Statistics on NHS stop smoking services in England, April 2008 to September 2008 (Q2 – Quarterly report)*. www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/nhs-stop-smoking-services/statistics-on-nhs-stop-smoking-services-in-england-april-2008-to-september-2008-q2--quarterly-report

EXPERIMENTAL STATISTICS

Number setting a quit date and successful quitters, by type of pharmacotherapy received, April to September 2008.

England Numbers/Percentages

	Number setting a quit date	Number of successful quitters	Percentage who successfully quit
Numbers			
Total	273,164	133,704	49
Number who received NRT only	181,164	83,854	46
Number who received bupropion (Zyban) only	5,449	2,720	50
Number who received varenicline (Champix) only	57,414	34,797	61
Number who received both NRT and bupropion (Zyban)	861	432	50
Number who received both NRT and varenicline (Champix)	2,558	1,260	49
Number who did not receive any pharmacotherapies	11,415	5,579	49
Number where treatment option not known	13,775	5,062	37
Percentages			
Total	100	100	–
Number who received NRT only	67	63	–
Number who received bupropion (Zyban) only	2	2	–
Number who received varenicline (Champix) only	21	26	–
Number who received both NRT and bupropion (Zyban)	0	0	–
Number who received both NRT and varenicline (Champix)	1	1	–
Number who did not receive any pharmacotherapies	4	4	–
Number where treatment option not known	5	4	–

Source: adapted from *Lifestyle Statistics*, The NHS Information Centre, 2009.

The full summary of product characteristics (SPC) for the following products can be found on the electronic medications compendium website: http://emc.medicines.org.uk.

Table 5: Product specifications

Brand	Product	Treatment duration
NiQuitin CQ	**24hr patch** 21mg 14mg 7mg	**Adults (18+):** 6 weeks 2 weeks 2 weeks **Adolescents (12–18)** As adult
	Lozenge 4mg 2mg	**Adults (18+)** 12 weeks **Adolescents (12–18)** 12 weeks maximum
	Gum 4mg 2mg	**Adults (18+)** Use for up to 3 months and then gradually reduce gum use. When daily use is 1–2 pieces use should be stopped **Adolescents (12–18)** 12 weeks maximum
Nicotinell	**24hr patch** 21mg 14mg 7mg	**Adults (18+)** 3 months **Adolescents (12–18)** 12 weeks maximum
	Lozenge 2mg 1mg	**Adults (18+)** Withdraw treatment gradually after 3 months. Discontinue use when dose is reduced to 1–2 lozenges per day Maximum period of treatment: 6 months **Adolescents (12–18)** Not to be used in under 18s without recommendation from a physician
	Gum 4mg 2mg	**Adults (18+)** Reduce dose gradually after 3 months. Discontinue use when dose has been reduced to 1–2 pieces per day **Adolescents (12–18)** 12 weeks maximum

Continued overleaf >>

Table 5: Product specifications *continued*

Brand	Product	Treatment duration
Nicorette	**Invisi patch** 25mg 15mg 10mg	**Adults (18+)** 8 weeks 2 weeks 2 weeks **Adolescents (12–18)** The dose and method of use are as for adults, as data is limited in this age group. The recommended treatment duration is 12 weeks. If longer treatment is required, advice from an HCP should be sought
	16hr patch 15mg 10mg 5mg	**Adults (18+)** 8 weeks 2 weeks 2 weeks **Adolescents (12–18)** The dose and method of use are as for adults, as data is limited in this age group. The recommended treatment duration is 12 weeks. If longer treatment is required, advice from an HCP should be sought
	Nasal spray	**Adult (18+)** 12 weeks For 8 weeks use as required within maximum daily use guidelines. Reduce dose to 0 over following 4 weeks **Adolescents (12–18)** 12 weeks maximum
	Inhalator	**Adults (18+)** 12 weeks **Adolescents (12–18)** 12 weeks maximum
	Gum 4mg 2mg	**Adults (18+)** Reduce dose gradually after 3 months. When daily use is 1–2 pieces, use should be stopped **Adolescents (12–18)** 12 weeks maximum. Use for 8 weeks and then gradually reduce the dose over a 4-week period

Continued opposite››

Table 5: Product specifications *continued*

Brand	Product	Treatment duration
	Microtab	**Adults (18+)** Gradually reduce after 3 months **Adolescents (12–18)** 12 weeks maximum. Use for 8 weeks and then gradually reduce the dose over a 4-week period
Wockhardt	**Nicopatch** 21mg 14mg 7mg	**Adults (18+)** 3–4 weeks 3–4 weeks 3–4 weeks **Adolescents (<18 years)** Should not be used by people under 18 years of age without recommendation from an HCP
	Nicopass lozenge 1.5mg	**Adults (18+)** Maximum use 6 months. Treatment should be stopped when the dose is reduced to 1 to 2 lozenges daily **Adolescents (<18 years)** Should not be used by people under 18 years of age without recommendation from a physician
Pfizer	**Varenicline (Champix)**	**Adults (18+)** 12 weeks + 12 weeks – refer to NICE **Adolescents (12–18)** Contraindicated for under-18s
GlaxoSmith Kline	**Bupropion (Zyban)**	Adults (18+) 8–9 weeks **Adolescents (12–18)** Contraindicated for under-18s

FACTORS AFFECTING THE METABOLISM OF NICOTINE

Certain factors, including gender, pregnancy and oral contraception, can affect the rate at which a smoker metabolises nicotine. This may have implications for the choice and strength of pharmacotherapy required.

Fast metabolism of nicotine from NRT products means that some quitters will need higher doses to control their cravings and other withdrawal symptoms. This is especially relevant to pregnant smokers who may need higher doses of NRT but who may be concerned or cautious about using it. Where appropriate, stop smoking advisers should advise pregnant women to use NRT in line with the product specification but should be especially careful about this client group under-dosing or stopping the treatment early.

Factor	Effect
Gender	Women metabolise nicotine **15%** faster than men
Pregnancy	Pregnant women metabolise nicotine up to **60%** faster
Oral contraceptive	Women using an oral contraceptive metabolise nicotine **40%** faster

NICOTINE REPLACEMENT THERAPY (NRT)

Evidence rating: A

NRT is safe and effective and when used in isolation (without additional behavioural support) approximately doubles the chances of long-term abstinence.[45, 46] There are six different types of NRT: patch (24hr and 16hr), gum, lozenge, microtab, nasal spray and inhalator. There is no evidence to suggest that one type of NRT is more effective than another (see Table 6) so product selection should be guided by client preference.

45 Silagy C, Lancaster T, Stead L, Mant D and Fowler G (2004) 'Nicotine replacement therapy for smoking cessation'. *Cochrane Database of Systematic Reviews* 2004, Issue 3. Art. No.: CD000146. DOI: 10.1002/14651858. CD000146.pub2

46 Stead LF, Perera R, Bullen C, Mant D and Lancaster T (2008) 'Nicotine replacement therapy for smoking cessation'. *Cochrane Database of Systematic Reviews* 2008, Issue 1. Art. No.: CD000146. DOI: 10.1002/14651858.CD000146.pub3

Table 6: Effectiveness of different forms of nicotine replacement therapy

Form of replacement	*RR*	*95% CI*	*Trials, n*
Any form	1.58	1.50–1.66	
Nasal spray	2.02	1.49–3.73	4
Tablets/lozenges	2.00	1.63–2.45	6
Inhalers	1.90	1.36–2.67	4
Patches	1.66	1.53–1.81	41
Gum	1.43	1.33–1.53	53

RR: risk ratio of abstinence relative to control

Source: Stead et al. (2008)[47]

NRT with special population groups

Following a review by the Medicines and Healthcare products Regulatory Agency (MHRA) in 2005, NRT can now be used by adolescents aged 12+, pregnant women and people with cardiovascular disease. Full details of the report can be found on the MHRA website: www.mhra.gov.uk/SearchHelp/Search/Searchresults/index.htm?within=Yes&keywords=smoking+cessation.

COMBINATION THERAPY

Evidence rating: A

A combination of NRT products (combination therapy) has been shown to have a moderate advantage over using just one product.[48,49] It is also considered cost effective.[50] NHS Stop Smoking Services should therefore offer clients combination therapy whenever appropriate: for example, to people with a high level of dependence on nicotine or who have found single forms of NRT inadequate in the past.[51]

47 Stead LF, Perera R, Bullen C, Mant D and Lancaster T (2008) 'Nicotine replacement therapy for smoking cessation'. *Cochrane Database of Systematic Reviews* 2008, Issue 1. Art. No.: CD000146. DOI: 10.1002/14651858.CD000146.pub3

48 Silagy C, Lancaster T, Stead L, Mant D and Fowler G (2004) 'Nicotine replacement therapy for smoking cessation'. *Cochrane Database of Systematic Reviews* 2004, Issue 3. Art. No.: CD000146. DOI: 10.1002/14651858. CD000146.pub2

49 Stead LF, Perera R, Bullen C, Mant D and Lancaster T (2008) 'Nicotine replacement therapy for smoking cessation'. *Cochrane Database of Systematic Reviews* 2008, Issue 1. Art. No.: CD000146. DOI: 10.1002/14651858.CD000146.pub3

50 Stapleton J, Watson L, Spirling LI, Smith R, Milbrandt A, Ratcliffe M and Sutherland G (2007) 'Varenicline in the routine treatment of tobacco dependence: a pre-post comparison with nicotine replacement therapy and an evaluation in those with mental illness'. *Addiction* 2007; 103(1): 146–54

51 National Institute for Health and Clinical Excellence (2008) *Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities*. NICE

PRELOADING/NICOTINE-ASSISTED REDUCTION TO STOP (NARS)

Evidence rating: **B**

There is some evidence that using the nicotine patch for a short period before a quit attempt results in higher cessation rates.[52] Using NRT while cutting down on cigarettes can be helpful for heavy smokers who find stopping in one step too difficult. Systematic reviews found that NRT while smoking significantly increases the likelihood of long-term abstinence[53] and the odds of cessation.[54] However, there is insufficient evidence about the long-term benefits of interventions intended to help smokers reduce but not stop smoking.

BUPROPION (ZYBAN)

Evidence rating: **A**

Bupropion is an antidepressant medication that can almost double the chances of long-term abstinence.[55] It is a prescription-only medication and should not be used in combination with any other stop smoking medications.[56] There is no evidence to show whether bupropion is less or more effective than NRT, although three randomised controlled trials (RCTs) have shown it to be less effective than varenicline on long-term abstinence.[57]

Cautions and adverse effects

Although a safe medication, bupropion does have a number of contraindications and cautions that should be taken into account before it is recommended to a client. The decision to use bupropion must depend on client preference and prior consideration of its contraindications and cautions. The SPC for bupropion can be found on the electronic medications compendium website: http://emc.medicines.org.uk.

52 Silagy C, Lancaster T, Stead L, Mant D and Fowler G (2004) 'Nicotine replacement therapy for smoking cessation'. *Cochrane Database of Systematic Reviews* 2004, Issue 3. Art. No.: CD000146. DOI: 10.1002/14651858. CD000146.pub2

53 Wang D, Connock M, Barton P, Fry-Smith A, Aveyard P and Moore D (2008) 'Cut down to quit' with nicotine replacement therapies in smoking cessation: A systematic review of effectiveness and economic analysis. *Health Technology Assessment*; 12(2): 1366–5278

54 Stead L and Lancaster T (2007) 'Interventions to reduce harm from continued tobacco use'. *Cochrane Database of Systematic Reviews* 2007(3): CD005231. Wiley InterScience

55 Hughes J, Stead L and Lancaster T (2007) 'Antidepressants for smoking cessation'. *Cochrane Database of Systematic Reviews* 2007(1): CD000031. Wiley InterScience

56 National Institute for Health and Clinical Excellence (2008) *Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities*. NICE

57 Cahill K, Stead L and Lancaster T (2007) 'Nicotine receptor partial agonists for smoking cessation'. *Cochrane Database of Systematic Reviews* 2007(1): CD006103. Wiley Interscience

VARENICLINE (CHAMPIX)

Evidence rating: **A**

A prescription-only drug, varenicline has been shown to increase the chances of long-term abstinence two-to-three fold.[58] Three RCTs have shown it to be more effective than bupropion.[59]

Cautions and adverse effects

A 2007 Cochrane review reported the most common adverse effect as mild to moderate levels of nausea that subsided over time.[60] The decision to use varenicline must depend on client preference and prior consideration of its cautions. These are listed in the SPC, which can be accessed on the electronic medications compendium website: http://emc.medicines.org.uk.

Depression, suicide ideation and suicide attempts

The following appears within the SPC for varenicline:

> Depression, suicidal ideation and behaviour and suicide attempts have been reported in patients attempting to quit smoking with Champix in the post-marketing experience. Not all patients had stopped smoking at the time of onset of symptoms and not all patients had known pre-existing psychiatric illness. Clinicians should be aware of the possible emergence of significant depressive symptomatology in patients undergoing a smoking cessation attempt, and should advise patients accordingly. Champix should be discontinued immediately if agitation, depressed mood or changes in behaviour that are of concern for the doctor, the patient, family or caregivers are observed, or if the patient develops suicidal ideation or suicidal behaviour.
>
> Depressed mood, rarely including suicidal ideation and suicide attempts, may be a symptom of nicotine withdrawal. In addition, smoking cessation, with or without pharmacotherapy, has been associated with exacerbation of underlying psychiatric illness (e.g. depression).

All services should be aware of this advice and have a local care pathway in place.

58 Cahill K, Stead L and Lancaster T (2007) 'Nicotine receptor partial agonists for smoking cessation'. *Cochrane Database of Systematic Reviews*, issue 1: CD006103. Wiley Interscience
59 Ibid.
60 Ibid.

WORKING WITH THE PHARMACEUTICAL INDUSTRY

In February 2008, DH published *Best practice guidance for joint working between the NHS and the pharmaceutical industry.* This publication shows NHS staff how to maintain the balance between partnership and ethical working. A copy is available on the DH website at:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082370

OTHER PRODUCTS AND THEIR EVIDENCE BASE

There are many other products and interventions, some of which are marketed as aids to stopping smoking. These are listed in the tables below (adapted from the New Zealand Smoking Cessation Guidelines 2007) along with their current evidence base.

Table 7: Evidence of no effectiveness

Product	Evidence
Hypnosis	Hypnosis does not improve long-term abstinence rates.[61]
Acupuncture, acupressure, laser therapy and electrostimulation	These do not improve long-term abstinence rates over placebo effect.[62, 63]
Anxiolytics (i.e. diazepam)	There is no evidence that such drugs are effective in stopping smoking.[64]
Incentives/competitions	Incentives have been shown to increase participation rates although this does not necessarily propel more people into successfully stopping smoking. Evidence shows that incentives/competitions do not increase long-term abstinence rates.[65]

61 Abbot NC, Stead LF, White AR and Barnes J (2006) 'Hypnotherapy for smoking cessation'. *Cochrane Database of Systematic Reviews* (2): CD001008

62 White AR, Rampes H and Campbell JL (2006) 'Acupuncture and related interventions for smoking cessation'. *Cochrane Database of Systematic Reviews* (2): CD000009

63 USDHHS (2000) *Treating Tobacco Use and Dependence*. Rockville, MD: United States Department of Health and Human Services, Agency for Healthcare Research Quality

64 Lancaster T and Stead LF (2006) 'Physician advice for smoking cessation'. *Cochrane Database of Systematic Reviews* (2): CD000165

65 Hey K and Perera R (2006) 'Competitions and incentives for smoking cessation'. *Cochrane Database of Systematic Reviews* (2): CD004307

Table 8: Some evidence of effectiveness

Product	Evidence
Rapid smoking	RCT evidence suggests this can improve 6-month abstinence rates. However, due to the possible harmful effects, i.e. increased heart rate, systolic blood pressure and carboxyhaemoglobin, this intervention should not be used.[66, 67]
Cytisine	There are dated and limited studies which indicate this plant alkaloid may be a useful stop smoking aid. Further research is required, however, before it can be recommended for use.[68, 69, 70, 71]

Table 9: Insufficient evidence

There is insufficient evidence on the following interventions/products to draw any conclusions:

Intervention/ product	Evidence
Allen Carr	RCT data is required to assess true efficacy.
Nicobrevin	Two trials suggest a potential effect on short-term outcomes but as both studies had problems with their methodologies, the results should be considered with caution. There is no evidence to show long-term effect on abstinence.
NicoBloc	One small, well-designed, randomised, double-blind placebo-controlled trial showed no benefit over placebo.[72]
St John's wort	Due to its potential antidepressant properties, some believed St John's wort may also prove a useful aid to stopping smoking. However, two small studies suggest that a dose of 600mg per day has no effect on smoking cessation.[73, 74]

Continued overleaf >>

66 USDHHS (2000) *Treating Tobacco Use and Dependence*. Rockville, MD: United States Department of Health and Human Services, Agency for Healthcare Research Quality
67 Hajek P and Stead LF (2006) 'Aversive smoking for smoking cessation'. *Cochrane Database of Systematic Reviews* (2).
68 Paun D and Franze J (1968) 'Breaking the smoking habit using cytisine containing "Tabex" tablets'. *Deutsche Gesundheitswesen* 23(44):2088–91
69 Scharfenberg G, Benndorf S and Kempe G (1971) 'Cytisine (Tabex) as a pharmaceutical aid in stopping smoking'. *Deutsche Gesundheitswesen* 26(10):463–5
70 Schmidt F (1974) 'Medical support of nicotine withdrawal. Report on a double blind trial in over 5000 smokers' (author's transl). . *Münchener Medizinische Wochenschrift* 116(11):557–64
71 Ostrovskaya TP (1994) 'Clinical trial of antinicotine drug-containing films'. *Biomedical Engineering*. 28(3):168–71
72 Gariti P, Alterman AI, Lynch KG, Kampman K and Whittingham T (2004) 'Adding a nicotine blocking agent to cigarette tapering'. *Journal of Substance Abuse Treatment* 27(1):17–25
73 Becker B, Bock B and Carmona-Barros R (2003) 'St John's Wort oral spray found to reduce withdrawal symptoms (POS4-82)'. *Society for Research on Nicotine and Tobacco* 9th Annual Meeting February 2003
74 Barnes J, Barber N, Wheatley D and Williamson EM (2006) 'A pilot, randomised, open, uncontrolled, clinical study of two dosages of St John's Wort (*Hypericum perforatum*) herb extract (LI-160) as an aid to motivational/behavioural support in smoking cessation'. *Planta Medica* 72(4):378–82

Table 9: Insufficient evidence *continued*

Intervention/ product	Evidence
Glucose	This shows a positive effect on abstinence rates when used in combination with NRT or bupropion.[75, 76] Contraindicated for diabetics.
Lobeline	This is a plant-based partial nicotine agonist, structurally similar to nicotine. There are a number of controlled trials that report on short-term outcome but none showed the benefit of lobeline over the control.
Exercise	There is some evidence to suggest exercise can have a positive effect on relieving tobacco withdrawal symptoms and short-term abstinence rates.[77, 78, 79, 80] Furthermore, exercise may increase self-esteem and assist in managing post-quit weight gain.[81] A systematic review of 12 studies that compared exercise with a passive condition found positive effects on cigarette cravings, withdrawal symptoms and smoking behaviour. This suggests that exercise can be a useful aid to managing cigarette cravings and withdrawal symptoms.[82]

Note:
Despite the increased awareness of electronic cigarettes, these are not currently marketed as smoking cessation aids in the UK. There is currently no evidence to suggest any effect on cessation.

75 West R and Willis N (1998) 'Double-blind placebo controlled trial of dextrose tablets and nicotine patch in smoking cessation'. *Psychopharmacology* 136(2):201–4
76 West R, Courts S, Beharry S, May S and Hajek P (1999) 'Acute effects of glucose tablets on desire to smoke'. *Psychopharmacology* 101:555–9
77 Ussher M, West R, Doshi R and Sampuran AK (2006) 'Acute effect of isometric exercise on desire to smoke and tobacco withdrawal symptoms'. *Human Psychopharmacology* 21(1):39–46
78 Ussher M, West R, McEwen A, Taylor A and Steptoe A (2003) 'Efficacy of exercise counselling as an aid for smoking cessation: a randomized controlled trial'. *Addiction* 98(4):523–32
79 Bock BC, Marcus BH, King TK, Borelli B and Roberts MR (1999) 'Exercise effects on withdrawal and mood among women attempting smoking cessation'. *Addictive Behaviors* 24(3):399–410
80 Daniel J, Cropley M, Ussher M and West R (2004) 'Acute effects of a short bout of moderate versus light intensity exercise versus inactivity on tobacco withdrawal symptoms in sedentary smokers'. *Psychopharmacology* 174(3):320–6
81 Ussher M (2006) 'Exercise interventions for smoking cessation'. *Cochrane Database of Systematic Reviews* (2)
82 Taylor AH, Ussher MH and Faulkner G (2007) 'The acute effects of exercise on cigarette cravings, withdrawal symptoms, affect and smoking behaviour: a systematic review'. *Addiction* 102, 534–43

Priority population groups

ROUTINE AND MANUAL GROUPS

Evidence rating: **B**

Smokers from routine and manual (R/M) groups make up 44% of the overall smoking population. The latest available data indicates that they account for a similar percentage of NHS Stop Smoking Services clients (when taken as a percentage of the three main socio-economic groups, which is the closest comparison that can be made).[83] However, the percentage varies considerably between regions and PCTs. PCTs will therefore need to ensure that local promotions target R/M smokers effectively.

Significant numbers of smokers who attempt to quit each year do so without evidence-based support. This is particularly true of smokers from R/M groups, who frequently opt for the 'cold turkey' approach, which is significantly less likely to be successful.

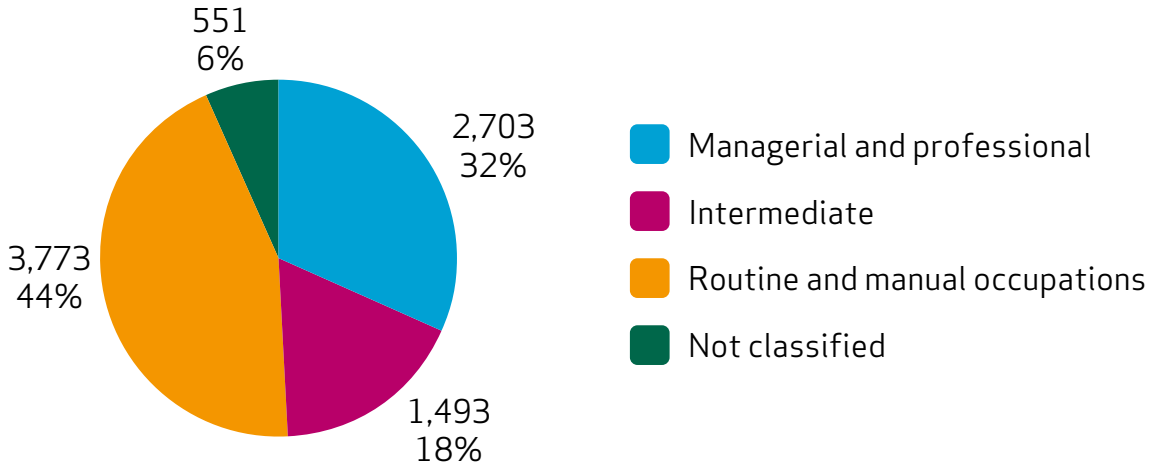
To track the throughput and success rates of R/M quitters they will also need to be better at coding socio-economic status. Given that national campaigns are now geared to have the greatest possible impact on R/M smokers, consistent use of national campaign materials will add significant weight to local promotions.

Progress is being made. Smoking rates within the R/M grouping have dropped 3% to 26% (compared with a drop of 1% to 21% in the overall adult population) on the previous year.[84] These figures indicate that DH is on track to achieve its Public Service Agreement (PSA) target to reduce adult smoking rates to 21% or less by 2010, with a reduction in prevalence in routine and manual groups to 26% or less. The scale of the challenge posed by the PSA target for R/M smoking prevalence should not, however, be underestimated.

83 NHS Information Centre (2009) *Statistics on NHS stop smoking services in England, April 2008 to September 2008 (Q2 – Quarterly report)*. www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/nhs-stop-smoking-services/statistics-on-nhs-stop-smoking-services-in-england-april-2008-to-september-2008-q2--quarterly-report

84 Office for National Statistics (2009) *Smoking and drinking among adults, 2007*. ONS. www.statistics.gov.uk/statbase/Product.asp?vlnk=5756

SMOKERS IN ENGLAND BY SOCIO-ECONOMIC CLASSIFICATION, THOUSANDS AND PER CENT



Source: ONS 2009

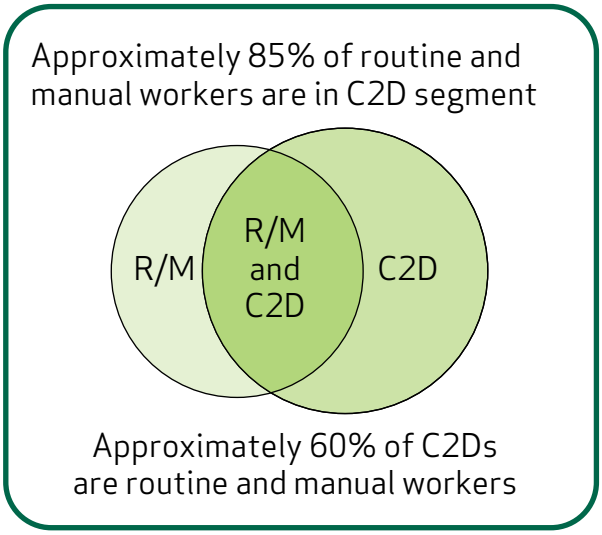
Who are R/M smokers?

In 2007, there were an estimated 14.4 million people in R/M groups. Nearly 60% were male, 42% were aged 25–44 (compared with 35% of the general population) and 39% had children aged 0–15 (compared with 31% of the general population). There were approximately 3.8 million R/M smokers. Smoking prevalence was higher among men (28%) than women (24%). There is a significant overlap between the R/M population and the C2D socio-economic grouping.

R/M OCCUPATIONS AND THE GENDER DIVIDE

Male R/M Occupations	Female R/M Occupations
Transport and haulage (363K HGV drivers)	Sales and retail (884K)
Construction (169K labourers, 139K construction trades)	Carers (581K)
Manufacturing (139K in metal work and maintenance)	Cleaners/domestic staff (549K)
Sales and retail (233K)	Educational assistants (295K)
Other blue-collar trades (174K van drivers, 154K carpenters)	Kitchen/catering (288K assistants, 113K chefs/cooks)
Security (156K security guards)	Receptionists (220K)
	Hairdressers (109K)

OVERLAP BETWEEN R/M AND C2D POPULATION GROUPS



Research insights into R/M smokers

Evidence from recent research provides some insight into smoking and quitting behaviour among R/M groups. Smoking is strongly associated with social disadvantage, and higher levels of prevalence and tobacco addiction are often found in the most disadvantaged areas.[85] Disadvantaged smokers, however, are just as likely to want to quit as affluent smokers.[86] The lack of a significant decline in prevalence in this group may be partially due to the barriers which affect service use but also relate to issues associated with addiction and wider life circumstances. A number of studies have been undertaken with smokers to identify these types of barriers and explore how they can be overcome. These have been summarised in a recent review for NICE.[87]

The review highlights a study by Roddy and colleagues[88] who conducted focus groups with 39 socio-economically deprived smokers in Nottingham. These were used to explore how the smokers viewed cessation services and aimed to identify specific barriers and motivations to improve access to cessation services. The study concluded that these smokers displayed a fear of being judged and fear of failure, and demonstrated a lack of correct knowledge about cessation services and the medication available. It was recommended that services be promoted in a personalised, non-judgemental and flexible manner.

85 Jarvis MJ and Wardle J (1999) 'Social patterning of individual behaviours: the case of cigarette smoking' in *Social Determinants of Health* edited by Marmot M and Wilkinson RG. Oxford University Press

86 Office for National Statistics (2002) *Smoking Related Behaviour and Attitudes 2002*. ONS www.statistics.gov.uk/downloads/theme_health/Smoking_Related_2002.pdf

87 Bauld L, McNeill A, Hackshaw L and Murray R (2007) 'Smoking cessation interventions to reduce the rate of premature death in disadvantaged areas: A systematic review'. www.nice.org.uk/guidance/index.jsp?action=download&o=37495

88 Roddy E, Antoniak M, Britton J, Molyneux A and Lewis S (2006) 'Barriers and motivators to gaining access to smoking cessation services amongst deprived smokers – a qualitative study'. *BMC Health Services Research* 6:147

Another study conducted by Wiltshire and colleagues[89] involved interviews with 100 disadvantaged smokers in Edinburgh to investigate their perceptions of smoking and past experiences of quit attempts. The study found that smokers lack the motivation to access cessation services unless they feel they will not only get help with their nicotine addiction but also with the wider life circumstances, routines and stressors linked to their smoking habits.

More recent work by Kotz and West,[90] using data from the Smoking Toolkit Study, shows that smokers in more deprived groups are just as likely as those in higher groups to try to stop and use aids to cessation, but there is a strong gradient across socio-economic groups in success. Those in the lowest group are half as likely to succeed compared with those in the highest. Determining the cause of, and counteracting, this gradient is paramount in reducing health inequalities.

Higher levels of nicotine addiction may be one factor explaining this. Kotz and West's study confirms previous reports of higher nicotine dependence scores in smokers from more deprived groups and nicotine dependence can predict failure of attempts to stop smoking. However, other factors have a role to play. Smokers in more deprived groups will have more smokers in their immediate circle of family, co-workers and friends. They may also have higher levels of stress which can play a role in relapse.[91]

All service users should be asked their occupational grouping, to ensure the service provision is equitable. Annex H provides a guide to this process (see Annex H, page 105).

Working with R/M employers

As R/M smokers are concentrated in relatively few industry sectors, the national marketing team has increased its focus on targeting employers to raise awareness of free NHS stop smoking support among their employees. Activities have included distributing Smokefree material to the staff of large R/M employers such as retail and catering firms and, where possible, working with local NHS Stop Smoking Services to provide on-site support sessions. Services may also want to consider working with firms' occupational health departments to provide referrals or training their staff to provide brief interventions.

A new toolkit is being developed to support local NHS workplace stop smoking advisers. This will include case studies, advice on targeting, template presentations and leaflets. It will be available from the extranet: http://smokefree.nhs.uk/resources/.

89 Wiltshire S, Bancroft A, Parry O and Amos A (2003) '"I came back here and started smoking again": perceptions and experiences of quitting smoking among disadvantaged smokers'. *Health Education Research* 18 (3):292–303

90 Kotz D and West R (2009) 'Explaining the social gradient in smoking cessation: It's not in the trying, but in the succeeding'. *Tobacco Control* 18: 43–6

91 Ibid.

HOSPITALISED AND PRE-OPERATIVE PATIENTS

Evidence rating: **A**

Planned admissions

Stopping smoking before an operation decreases the risk of wound infection, delayed wound healing and post-operative pulmonary and cardiac complications. It can often mean a shorter stay in hospital. This is therefore a good opportunity for a successful intervention.

A recent Cochrane review reported that delivering stop smoking services to in-patients has a positive impact. Trials found that programmes begun during a hospital stay, and which included follow-up support for at least one month after discharge, are effective.[92]

Recommendations

- ☐ All patients should receive brief intervention advice in advance of any surgical intervention and be referred for more intensive support from their local NHS Stop Smoking Service (see page 33).
- ☐ Patients who do not intend to stop smoking prior to surgery should be advised of the hospital's Smokefree policy. As smokers are likely to experience withdrawal symptoms during a period of enforced abstinence, pharmacotherapy should be offered to assist withdrawal management and provided through primary care.

Unplanned admissions

It is thought that people are more receptive to health advice and support while they are in hospital, and particularly following an unplanned admission. This therefore offers a prime opportunity to offer stop smoking advice, using the period of heightened motivation to stop smoking, encourage Smokefree compliance and highlight any need for withdrawal management.

Recommendations

- ☐ If the patient wishes to stop smoking following admission to hospital they should be given brief intervention and referred for intensive support.
- ☐ All smokers' nicotine dependency scores should be assessed following admission and NRT provided as soon as possible.
- ☐ Patients should not have to wait for their local NHS Stop Smoking Service (either provided internally or externally) to assess them before receiving NRT.
- ☐ NHS Stop Smoking Services should be prepared to support patients who have stopped smoking in hospital once they return to the community. Discharge information from the hospital will need to be communicated to the service via a locally agreed system.

92 Rigotti NA, Munafo MR and Stead LF (2008) 'Interventions for smoking cessation in hospitalised patients'. *The Cochrane Database of Systematic Reviews*. Issue 2. Art. No.CD001837.DOI:10.1002/14651858.CD001837.pub.2

Stop smoking interventions in secondary care

The DH Tobacco Policy Team, with the aid of an expert working group, is currently working on a guide that will help NHS Stop Smoking Services develop planned and unplanned stop smoking support across acute settings. The stop smoking interventions in secondary care guidance is based on the premise that planned and unplanned admissions to hospital provide ideal opportunities to support people in stopping smoking.
It is planned to be available via regional performance managers (RPMs) and on the extranet in early 2009.

Commissioning tool

In addition, NICE is currently developing a tool to help NHS Stop Smoking Services demonstrate the financial and clinical impact of pre-operative stop smoking support services in acute settings to both acute and primary care commissioners. It should be published some time in 2009.

BLACK AND ETHNIC MINORITY GROUPS

Evidence rating: **B**

Some black and minority ethnic (BME) communities have high smoking prevalence rates as compared with the general population (see Table 10). Rates are highest among Bangladeshi, Irish and Pakistani males.

It is therefore especially important that local authorities (LAs) and PCTs with significant BME populations carry out local mapping and joint needs assessments. They will then be able to tailor their services and promotions appropriately. Many LAs have chosen smoking as a key indicator under their Local Area Agreements (LAAs) and some have specific targets for reducing smoking prevalence within local BME populations.

There has been a wide range of innovative work to deliver NHS Stop Smoking Services to BME communities across the country. Specific guidance has been issued by Communities and Local Government (CLG) to highlight models of good practice and ways of increasing service uptake by smokers from local BME communities.[93]

A number of areas have been networking with local faith groups and using local multi-lingual media to promote NHS Stop Smoking Services. The growing body of health trainers, recruited from local communities, have also been referring smokers from BME communities to NHS, voluntary and private sector organisations.

93 Communities and Local Government (2008) *Working with Black and Minority Ethnic Communities – A guide for Stop Smoking Service managers*. www.communities.gov.uk/publications/communities/stopsmoking

NHS ASIAN TOBACCO HELPLINES:

Urdu	0800 169 0 881
Punjabi	0800 169 0 882
Hindi	0800 169 0 883
Gujarati	0800 169 0 884
Bengali	0800 169 0 885

These helplines, managed by DH, are available every Tuesday between 1.00pm and 9.00pm. Printed resources in the above languages are also available.

Table 10: Ethnicity, gender and smoking

Self-reported cigarette smoking by sex and ethnic group (adults aged 16 and over), England, 2004[94]

	General population	Black Caribbean	Indian	Pakistani	Bangladeshi	Chinese	Irish
	%	%	%	%	%	%	%
MEN	24	25	20	29	40	21	30
WOMEN	23	24	5	5	2	8	26

Source: *Health Survey for England 2004: Health of Ethnic Minorities*

94 NHS Information Centre (2006) *Health Survey for England 2004: Health of Ethnic Minorities*. www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles-related-surveys/health-survey-for-england/health-survey-for-england-2004:-health-of-ethnic-minorities--full-report

CHILDREN AND YOUNG PEOPLE

Evidence rating: I

There is little published evidence of the effects of interventions that focus on cessation activity in adolescence.[95] Data from English NHS Stop Smoking Services shows a 22% CO-verified quit rate in the under-18 age group against 33% in all ages.[96]

Only 3% of service users who set a quit date were aged 18 or under, and this should be reflected in service provision. Services should be available for young people who want to stop smoking and local NHS Stop Smoking Services should link with other programmes to ensure they reach as many children and young people as possible (e.g. through healthy school programmes, health services on secondary school sites and other youth settings).

Prevention and tobacco control

Evidence rating: B

The evidence base for preventative strategies aimed at young people is improving. These include ASSIST[97] and wider tobacco controls aimed at denormalising smoking. These initiatives are driven by wider public health and tobacco control teams, however, so should not be a major focus of the clinical intervention service.

95 Thomas RE, Perera R (2006) 'School-based programmes for preventing smoking'. *Cochrane Database of Systematic Reviews*, Issue 3. Art. No.: CD001293. DOI: 10.1002/14651858.CD001293.pub2

96 NHS Information Centre (2009) *Statistics on NHS stop smoking services in England, April 2008 to September 2008 (Q2 – Quarterly report)*. www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/nhs-stop-smoking-services/statistics-on-nhs-stop-smoking-services-in-england-april-2008-to-september-2008-q2--quarterly-report

97 See: www.thelancet.com/journals/lancet/article/PIIS0140-6736(08)60692-3/fulltext

MENTAL HEALTH

Evidence rating: **B**

On 1 July 2008, it became a legal requirement for all mental health facilities to be smoke free. This presents a particular challenge since smoking prevalence among people with mental health problems is far greater than that of the general population: 44% of the total cigarettes smoked in a nationally representative sample were by those with a mental illness.[98]

Smoking tobacco is significantly associated with increased prevalence of all major psychiatric disorders,[99] with smokers twice as likely to suffer from a mental health problem than non-smokers and more likely to commit suicide.[100]

People with mental illnesses are likely to be heavier, more dependent smokers and have smoked longer than smokers in the general population.[101] In a large population survey of psychiatric morbidity in the UK, 64% of those with probable psychosis were smokers compared with 29% without psychosis.[102] The highest levels of smoking occur within psychiatric in-patient settings, where up to 70% of patients are smokers and 50% are heavy smokers.[103]

Such high levels of smoking increase the amount of smoking-related harm people with mental health disorders suffer. It is responsible for a large proportion of the excess mortality of people with mental health problems.[104] The death rate from respiratory disease among people with schizophrenia, for example, is ten-fold compared with the average.[105] It is therefore crucial that people with mental health problems should have appropriate access to stop smoking support and be encouraged to stop.

Positive effects of intervention

Evidence suggests there is a link between the amount smoked and the number of depressive and anxiety symptoms.[106] On stopping, these symptoms are seen to reduce,[107]

98 Lasser K, Wesley Boyd J, Woolhander S et al. (2000) 'Smoking and mental illness: A population-based prevalence study'. *JAMA* 284: 2606–10
99 Farrell M, Howes S, Bebbington P et al. (2001) 'Nicotine, alcohol and drug dependence and psychiatric comorbidity: Results of a national household survey'. *British Journal of Psychiatry* 179: 432–7
100 Malone KM, Waternaux C, Haas GL et al. (2003) 'Cigarette Smoking, Suicidal Behavior, and Serotonin Function in Major Psychiatric Disorders'. *American Journal of Psychiatry* 160(4): 773–9
101 Kumari V and Postma P (2005) 'Nicotine use in schizophrenia: the self medication hypotheses'. *Neuroscience and Biobehavioural Reviews* 29: 1021–34
102 Coultard M, Farrell M, Singleton N and Meltzer H (2000) *Tobacco, alcohol and drug use and mental health*. DH. London: Stationery Office
103 Jochelson J and Majrowski B (2006) 'Clearing the air: Debating smoke-free policies in psychiatric units'. King's Fund
104 Brown S, Barraclough B and Inskip H (2000) 'Causes of the excess mortality of schizophrenia'. *British Journal of Psychiatry* 176: 109
105 Joukamaa M, Heliovaara M, Knekt P et al. (2001) 'Mental disorders and cause-specific mortality'. *British Journal of Psychiatry* 179: 498–502
106 Farrell M, Howes S, Bebbington P et al. (2001) 'Nicotine, alcohol and drug dependence and psychiatric comorbidity: Results of a national household survey'. *British Journal of Psychiatry* 179, 432–7
107 Campion J, Checinski K, Nurse J and McNeill A (2008) 'Smoking by people with mental illness and benefits of smoke-free mental health services'. *Advances in Psychiatric Treatment* 14: 217–28

although a minority of people with depression who stop smoking experience an increase in depressive symptoms.[108]

In people with schizophrenia, however, there is little evidence to show any worsening of symptoms following stopping smoking.[109] Stopping smoking can result in significant reductions in the dosages of mental health medications and reducing doses will reduce the long-term consequences such medication can have.

Supporting people with mental health problems in stopping smoking can therefore have a direct impact on reducing health inequalities. However, health inequality experienced by people with mental illness will widen if investment in smoking cessation services for this group is not greater than for the general population.

Making access to smoking cessation services easier for those with disability due to severe mental disorder will also comply with the Equality Act.

Stopping smoking and depression

Depressed mood, that in rare cases includes suicidal ideation and suicide attempts, may be a symptom of nicotine withdrawal. Smoking cessation, with or without pharmacotherapy, has also been associated with the exacerbation of underlying psychiatric illness (e.g. depression). Stop smoking advisers should be aware of the possible emergence of significant depressive symptomatology in clients undergoing a smoking cessation attempt, and should advise patients accordingly.

Stopping smoking and medication

Smoking increases the metabolism of certain medications which can lead to lower plasma levels and greater doses are therefore needed to achieve a similar therapeutic effect. Upon stopping smoking, the metabolism of these medications may be reduced and people in this situation will need monitoring by a healthcare professional in case the dose they are taking needs adjusting.

Medications affected in this way include, among many others:

- benzodiazepines: diazepam, zotepine
- antipsychotic medication: clozapine, fluphenazine, perphanazine, haloperidol (partly), olanzapine (partly)
- antidepressants: tricyclics – tertiary (e.g. amitriptyline, clomipramine, desipramine, imipramine), fluvoxamine (partly), mirtazpine (partly)
- others, including: paracetamol, propranolol, tamoxifen, theophylline, verapamil, warfarin-R

108 Hughes JR (2007) 'Depression during tobacco abstinence'. *Nicotine Tob Res* 9:443–6
109 Campion J, Checinski K, Nurse J and McNeill A (2008) 'Smoking by people with mental illness and benefits of smoke-free mental health services'. *Advances in Psychiatric Treatment* 14: 217–28

Stopping smoking can also reduce the metabolism of some medication leading to higher, sometimes toxic blood levels over a few days.[110, 111]

It is therefore recommended that blood levels of clozapine should be measured before smoking cessation (as well as olanzapine if assays are available). With clozapine and olanzapine, 25% dose reduction should occur during the first week of cessation and further blood levels should be taken on a weekly basis until levels have stabilised. Dose reduction should only occur if the patient has stopped smoking and this should be reassessed throughout the quit attempt.

Doses of fluphenazine and benzodiazepine should be reduced by up to 25% in the first week of cessation, while tricyclic antidepressants may need to be reduced by 10-25% in the first week.[112]

Further dose reductions within British National Formulary levels may be required with continued cessation. If the person starts smoking again their medication dose must be reviewed, as the metabolism of the drug will again increase.

Stop smoking medication and mental health

NRT (see page 54)

NRT has no specific contraindications or cautions relating to mental health disorders.

Bupropion (see page 56)

Bupropion has been shown to be effective for people with depression and schizophrenia although it has been associated with increased anxiety and depression. It is contraindicated in bipolar disorder and should not be prescribed with drugs that increase risk of seizures, such as tricyclic antidepressants and some antipsychotics.[113] Bupropion can also increase blood levels of citalopram, which should be avoided for two weeks after stopping.[114] It is also contraindicated with monoamine oxidase inhibitors (MAOIs).

Varenicline (see page 57)

Varenicline is not contraindicated for use in mental health although the SPC advises particular care in patients with a previous history of psychiatric illness, and states that patients should be advised accordingly.

For a complete list of all contraindications and cautions, refer to the SPCs for each product available at http://emc.medicines.org.uk.

110 Campion J, Checinski K and Nurse J (2008) 'Review of smoking cessation treatments for people with mental illness'. *Advances in Psychiatric Treatment* 14: 208–16
111 Taylor D, Paton C and Kerwin R (2007) *Maudsley prescribing guidelines, 9th edition*. Informa Healthcare
112 Ibid.
113 Ibid.
114 British Medical Association and the Royal Pharmaceutical Society of Great Britain (2008) *British National Formulary*. BMJ Publishing group

Stop smoking interventions in mental health

Although there is insufficient evidence to suggest the best type of intervention for people with mental health problems, interventions which work for the general population also work for those with mental illness who experience disproportionate levels of smoking-related ill-health. Combining pharmacotherapy and other support such as counselling can increase abstinence rates in those with mental health problems to similar rates as for the general population.[115, 116] However, up to now people with mental illness have been less likely to receive smoking cessation interventions in primary care.[117]

Developing this evidence will come under the remit of the NHS Centre for Smoking Cessation and Training. In the meantime, however, the basic quality principles remain the same, wherever the intervention takes place:

- ☐ offer a menu of evidence-based support options
- ☐ ensure the intervention is delivered by a trained stop smoking adviser
- ☐ allow access to approved pharmacotherapy
- ☐ use CO verification in at least 85% of cases (see pages 42–45)
- ☐ provide support for the duration of the treatment episode

A sample care pathway, including these principles, can be found at Annex F.

Recommendations

There are a number of additional considerations that should be taken into account when providing stop smoking support for people with mental health problems in either community or acute settings.

Community settings:

- ☐ ensure that the local mental health trust is aware of the local NHS Stop Smoking Service
- ☐ train all mental health colleagues (including local community mental health teams and voluntary sector helpers) and ensure there is a referral pathway into the local NHS Stop Smoking Service
- ☐ approach the local mental health trust to co-ordinate basic training for *stop smoking advisers* to increase their confidence in dealing with mental health problems
- ☐ offer training for people working in primary care to help them understand the issues people with mental health problems face when they try to stop smoking

115 Campion J, Checinski K and Nurse J (2008) 'Review of smoking cessation treatments for people with mental illness'. *Advances in Psychiatric Treatment* 14:208–16

116 Foulds JGK, Steinberg MB, Richardson D et al. (2006) 'Factors associated with quitting smoking at a tobacco dependence treatment clinic'. *American Journal of Health Behavior* 30:400–412

117 Phelan M, Stradins L and Morrison S (2001) 'Physical health of people with severe mental illness'. *British Medical Journal* 322: 433–444

- ☐ maintain links with local mental health services and seek guidance when specific issues arise

Acute settings:

- ☐ seek out top level approval and support
- ☐ provide brief or intermediate training for staff
- ☐ ensure stop smoking medicines are available for patients who wish to stop smoking and those who require withdrawal management (i.e. those who do not wish to stop smoking but have limited access to outdoor space and opportunities to smoke and therefore experience nicotine withdrawal symptoms)
- ☐ ensure stop smoking medicines are available for staff
- ☐ create a clear pathway to maintain support once the patient has been discharged into the community

PREGNANCY

Evidence rating: **B**

Smoking is the single most modifiable risk factor for adverse outcomes in pregnancy. It is estimated to contribute to 40% of all infant deaths, a 12.5% increased risk of a premature birth and a 26.3% increased risk of intra-uterine growth restriction.[118] This therefore remains a key public health concern, particularly since early intervention (i.e. stopping smoking at three months gestation) significantly improves outcomes.[119]

Pregnant smokers should be offered a full range of services and there should be a robust care pathway that allows women to be tracked through their quit attempts. This should include biochemical verification (see Biochemical markers, page 42).

In 2008, 8,409 pregnant women set a quit date in the first two quarters with a success rate of 44% (3,724), 25% of which were CO validated.[120]

NRT IN PREGNANCY

Evidence rating: **C**

The evidence on the effectiveness and safety of NRT in pregnancy is inconclusive[121] although consensus opinion does suggest that using NRT during pregnancy is likely to be safer than continuing to smoke. The Smoking, Nicotine and Pregnancy (SNAP) trial is currently conducting further research in this area.[122]

However, we suggest that all women who smoke and who may be pregnant, or who smoke and are trying to become pregnant, should be offered a stop smoking service as soon as they make contact with HCPs such as midwives, GPs and pharmacists.

They should be referred to their local NHS Stop Smoking Service as early as possible, ideally in the pre-conception period by health professionals or early in the pregnancy. For example, the referral can be made when booking the first midwife visit.

Support for pregnant women should be provided by a trained stop smoking adviser and should include:

- ☐ personalised information, advice and support
- ☐ information about, and the offer of, NRT as per SPC

118 Gardosi J, Beamish N, Francis A, Williams M, Sahota M, Tonks A, McGeown P and Hart M. *Stillbirth and infant mortality, West Midlands 1997–2005: Trends, Factors, Inequalities*. The West Midlands Perinatal Institute
119 West R (2002) 'Smoking and pregnancy' *Fetal and Maternal Medicine Review* (13)3:181–194
120 NHS Information Centre (2009) *Statistics on NHS stop smoking services in England, April 2008 to September 2008 (Q2 – Quarterly report)*. www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/nhs-stop-smoking-services/statistics-on-nhs-stop-smoking-services-in-england-april-2008-to-september-2008-q2--quarterly-report
121 Coleman T, Thornton J, Britton J, Lewis S, Watts K, Coughtrie MW, Mannion C, Marlow N and Godfrey C (2007) 'Protocol for the smoking, nicotine and pregnancy (SNAP) trial: double-blind, placebo-randomised, controlled trial of nicotine replacement therapy in pregnancy'. *BMC Health Serv Res* 7:2
122 See: www.nottingham.ac.uk/chs/research/project_SNAP.php

This support should be available pre-pregnancy, during pregnancy and beyond.

When a pregnant woman sets a quit date, the midwife should be informed of the quit attempt, ideally by a record in the hand-held notes. Information on the quit attempt, including the type of support provided and its outcomes, should be passed to the health visitor in the post-natal period.

DEMOGRAPHIC VARIATIONS

There is a wide ethnic variation in smoking in pregnancy. The overall rate would be substantially higher if it was not for the low rates reported by some population groups (most notably those whose ethnicity is south Asian). Services should aim to reach and support women from BME groups in their locality.

Mothers in R/M occupations are also over four times more likely to have smoked throughout pregnancy than those in managerial and professional occupations.[123] NHS Stop Smoking Services should therefore find ways of targeting or continuing to target this group of women using, for example, referral pathways and outreach with community health professionals as well as partnerships with organisations such as Children's Centres. Services should also refer to the section on R/M smokers (see page 61) for guidance on this particular sector of the population.

IMPROVING DATA QUALITY

The quality of data on the smoking status of women during pregnancy and at delivery is poor in some areas. Efforts should be made to improve both the frequency of data recording and the quality of data collected.

123 NHS Information Centre (2007) *Infant Feeding Survey 2005*. Leeds: Information Centre for Health and Social Care

SMOKING CESSATION IN PREGNANCY: NICE GUIDANCE RECOMMENDATION 8[124]

Who should take action?

All those responsible for providing health and support services for pregnant women, for those wishing to become pregnant and for their partners. This includes those working in fertility clinics, midwives, GPs, dentists, hospital and community pharmacists, and those working in Children's Centres, voluntary organisations and occupational health services.

What action should they take?

At the first contact with the woman, discuss her smoking status; provide information about the risks of smoking to the unborn child and the hazards of exposure to secondhand smoke. Address any concerns she and her partner or family may have about stopping smoking.

Offer personalised information, advice and support on how to stop smoking. Encourage pregnant women to use local NHS Stop Smoking Services and the NHS Pregnancy Smoking Helpline by providing details on when, where and how to access them. Consider visiting pregnant women at home if it is difficult for them to attend specialist services.

Monitor smoking status and offer smoking cessation advice, encouragement and support throughout the pregnancy and beyond.

Discuss the risks and benefits of NRT with pregnant women who smoke, particularly those who do not wish to accept the offer of help from the NHS Stop Smoking Service. If a woman expresses a clear wish to receive NRT use professional judgement when deciding whether to offer a prescription.

Advise pregnant women to remove nicotine patches before going to bed.

Campaign material

The Department of Health has produced a new suite of campaign materials aimed at pregnant smokers, their partners and midwives. A toolkit has also been developed for midwives. This contains a Q&A booklet and a quick prompt guide, encouraging midwives sensitively to ask and record a client's smoking status and to advise that quitting is the best thing they can do to improve their health and the health of their baby. They should also recommend that pregnant smokers use the NHS Stop Smoking Services and the NHS Pregnancy Smoking Helpline.

124 National Institute for Health and Clinical Excellence (2008) *Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities*. London: NICE

THE NHS PREGNANCY SMOKING HELPLINE

The NHS Pregnancy Smoking Helpline (0800 169 9 169) is a call-back service that offers pregnant women support throughout their pregnancy at a time that is convenient for them. A number of other resources are available through the helpline as well as the Smokefree Resource Centre: www.smokefree.nhs.uk/resources.

TEENAGE PREGNANCY

Evidence rating: ✓

Teenage mothers are more likely than older mothers to have been smoking before they become pregnant. They are also less likely to stop smoking during their pregnancy (see Table 11). This group is therefore a priority for stop smoking support.

Table 11: Smoking during pregnancy[125]

Mother's age	% who smoked before or during pregnancy	% who smoked throughout pregnancy	% who gave up before or during pregnancy
20 or under	68	45	34
All ages	32	17	49

Recommendations for both NHS Stop Smoking Services and midwifery services on helping teenage smokers to quit can be found in the Department for Children, Schools and Families 2007 report Teenage Parents Next Steps: Guidance for Local Authorities and Primary Care Trusts.[126]

125 NHS Information Centre (2007) *Infant Feeding Survey 2005*. Leeds: Information Centre for Health and Social Care
126 Department for Children, Schools and Families (2007) *Teenage Parents Next Steps: Guidance for Local Authorities and Primary Care Trusts*. London: DCSF. www.everychildmatters.gov.uk/resources-and-practice/IG00250/

PRISONERS

Evidence rating: C

It has been estimated that around 80% of the prison population smokes.[127] Quarter 1 and 2 2008/09 data from the English NHS Stop Smoking Services shows that 4,083 quit dates were set in a prison setting with a self-reported success rate of 58% (2,348).[128]

There is not yet enough evidence to suggest what the best type of intervention for prison settings may be. It would seem appropriate, however, that interventions offered to the general population should be available to a group with such high levels of smoking and also high levels of mental illness. Developing further evidence for the most effective combination of interventions will be part of the NHS Centre for Smoking Cessation and Training's remit. In the meantime, the basic quality principles remain the same, irrespective of the intervention setting (see Annex G for an example care pathway):

- offer a menu of evidence-based support options
- ensure that the intervention is delivered by a trained stop smoking adviser
- allow access to approved pharmacotherapy
- CO validation to be used in at least 85% of cases (see CO section on page 42)
- provide support for the duration of the treatment episode.

DEPARTMENT OF HEALTH BEST PRACTICE CHECKLIST

Between April 2004 and March 2005, DH funded a study of smoking in prisons across the North West region.[129] The aims of the study were to:

- identify and assess various intervention models
- examine NRT usage and distribution
- collect and collate quarterly returns to provide quit rates among prisoners
- provide qualitative insight into the uptake and impact of NRT provision over the study period.

127 Singleton N, Farrell M and Meltzer H (1999) *Substance misuse among prisoners in England and Wales*. London: Office for National Statistics

128 NHS Information Centre (2009) *Statistics on NHS stop smoking services in England, April 2008 to September 2008 (Q2 – Quarterly report)*. www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/nhs-stop-smoking-services/statistics-on-nhs-stop-smoking-services-in-england-april-2008-to-september-2008-q2--quarterly-report

129 MacAskill S and Hayton P (2006) *Stop Smoking support in HM Prisons: the impact of nicotine replacement therapy – executive summary and best practice checklist*. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4134515. London: Department of Health

As part of the study a best practice checklist was developed aimed at helping prisoners to stop smoking. This included the following points:

- **Effective partnership development between the PCT and the prison**: this is essential for any intervention and means building relationships throughout the healthcare and wider prison system through continuous planning and feedback mechanisms for cessation and wider tobacco control issues.
- **A range of cessation delivery models should be available**, including both group and one-to-one support. These should offer flexible support that meets individual needs. Services can be offered through a range of prison staff, not just healthcare staff but others such as physical education instructors or prison officers. External stop smoking specialists may run support sessions but it is vital that internal prison staff remain involved.
- **Protected staff time and role development for those delivering the service need to be secured**: this means not just time for core interactions with quitters, but for administration and record-keeping activities which may be more demanding in prisons than in community settings. If dedicated time is set aside then prison staff and stop smoking advisers will be able to plan programme sessions in advance. There should be enough staff to provide a substantial service, led by an enthusiastic 'champion' who promotes the service, co-ordinates activities and liaises across organisations. Cessation can therefore form part of their core work.
- **Clear record keeping will make it easier to promote the service**: telling people what is happening and 'selling' the successes of the service is an important way of providing rewarding feedback to those delivering the service and making a case for future developments.
- **Assessing and exploiting the expressed desire to quit among prisoners** as well as interest from staff will contribute to building the service. Conducting needs assessments and keeping track of waiting lists will help.
- **Ring-fenced NRT budgets for prisoners** and long-term funding commitment are recommended. Efficient and economical ordering procedures and effective supply mechanisms should be developed across areas, in conjunction with prison pharmacies and pharmaceutical companies.
- **Straightforward NRT prescribing and dispensing** should be developed within the context of safety issues. Experience shows that dispensing NRT on a weekly basis, with used patches being returned, achieves a better balance between empowering prisoners and minimising the misuse of NRT as currency. Consistent guidance is needed, for example in the use of alternative NRT oral/non-gum products.
- **Staff training and ongoing support** by stop smoking specialist services will contribute to high standards and increase confidence among those delivering the service. Network meetings are valuable.

- **Care pathways** should be developed with mechanisms to cope with prisoners being transferred from one prison to another or released during a course of treatment (Prison Service Order 3050).
- **Staff cessation support should be considered**, within the prison or through links to community settings.
- **Being aware of relevant legislation and anticipating guidance** on prisoner health and workplace issues will help planning and preparation and so increase the effectiveness of interventions.

The full Prison Service Instruction regarding Smokefree legislation and its application to the Prison Service can be accessed at http://psi.hmprisonservice.gov.uk/PSI_2007_09_smoke_free_legislation.doc

Substance misuse

Evidence rating: C

SMOKING AND ALCOHOL

People who smoke everyday are more likely to have a co-morbid substance-use disorder than people who have never smoked.[130] Smoking at an early age is also associated with substance misuse.[131] The link between smoking and alcohol dependence is particularly strong,[132] with alcohol-use disorders significantly associated with regular heavy smoking.[133] Stopping smoking does not seem to make it more difficult to stop drinking although the evidence is contradictory and further studies are required.

SMOKING AND DRUGS

More than two thirds of drug misusers are regular tobacco smokers – double the rate of the general population.[134] One survey of outpatients in methadone maintenance clinics even found that 83% were smokers.[135] Smoking status has also been found to be predictive of illicit substance use in methadone maintenance programmes, although there is a significant relationship between rates of change in heroin use and rates of change in tobacco use.[136]

People who smoke tobacco are more likely to use cannabis and abuse alcohol. Using cannabis also makes smokers less likely to stop.[137] There is not yet enough evidence to show whether any particular method or type of cannabis use is unequivocally less harmful than another.

130 John U, Meyer C, Rumpf HJ et al. (2004) 'Smoking, nicotine dependence and psychiatric comorbidity – a population-based study including smoking cessation after three years'. *Drug and Alcohol Dependence* 76:287–95
131 Williams JM and Ziedonis DM (2004) 'Addressing tobacco among individuals with a mental illness or an addiction'. *Addictive Behaviours* 29:1067–83
132 Miller N and Gold M (1998) 'Comorbid cigarette and alcohol addiction: epidemiology and treatment'. *Journal of Addictive Disorders* 17:55–66.
133 Dierker LC, Avenevoli S, Stolar M et al. (2002) 'Smoking and depression: An examination of mechanisms of comorbidity'. *American Journal of Psychiatry*, 159:947–953
134 Zickler P (2000) 'Nicotine craving and heavy smoking may contribute to increased use of cocaine and heroin'. *NIDA Notes* 15(5)
135 Nahvi S, Richter K, Li X et al. (2006) 'Cigarette smoking and interest in quitting in methadone maintenance patients'. *Addictive Behaviours* 31(11):2127–34
136 Frosch DL, Nahom D and Shoptaw S (2002) 'Optimizing smoking cessation outcomes among the methadone maintained'. *Journal of Substance Abuse Treatment* 23(4):426–30
137 Ford D, Vua H and Anthony J (2002) 'Marijuana use and cessation of tobacco smoking in adults from a community sample'. *Drug and Alcohol Dependence* 67:243–48

RECOMMENDATIONS FOR NHS STOP SMOKING SERVICES

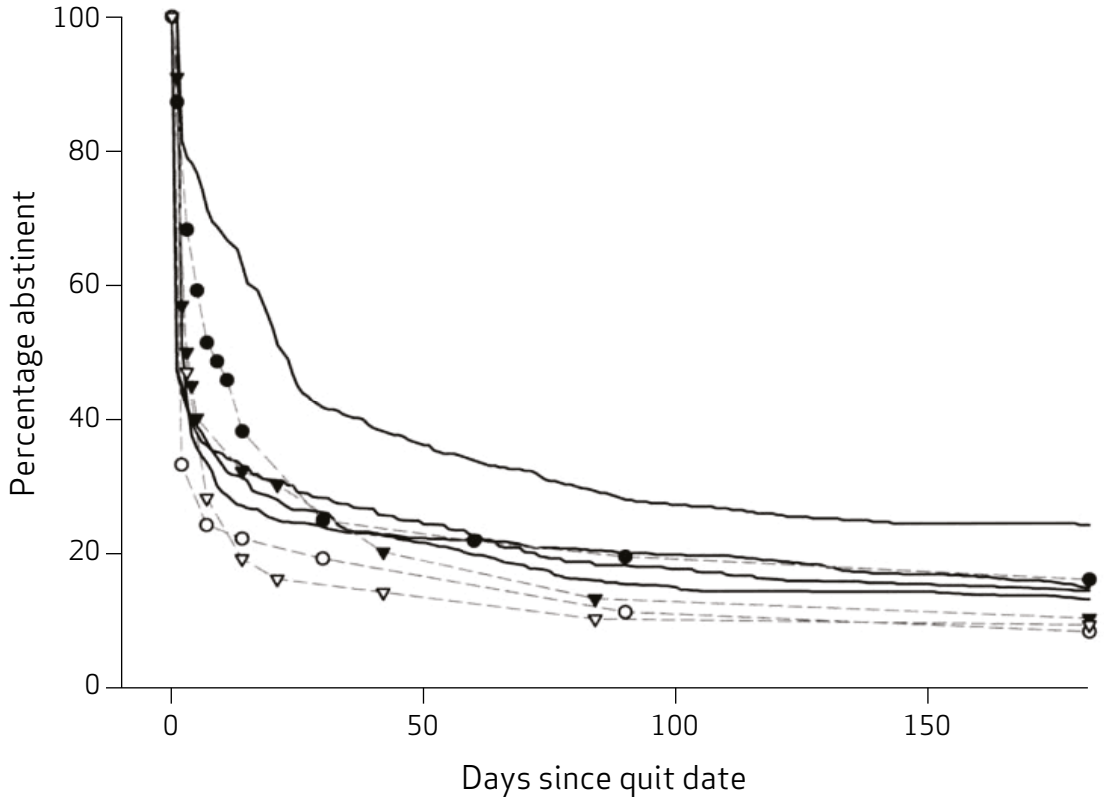
NHS Stop Smoking Services will encounter clients with dual dependencies – particularly if they have mental health problems or other substance misuse. Those with dual dependencies may find that their substance use increases their risk of relapsing back to tobacco use. We therefore recommend that services:

- **develop links with alcohol and drug services** within their area to create referral pathways from the drug or alcohol services into the stop smoking services and vice versa;
- **train colleagues in local drug and alcohol services, as appropriate,** in brief interventions (see page 33) in order to facilitate referrals into NHS Stop Smoking Services; and
- **train stop smoking advisers, as appropriate,** in substance misuse, so that they know how to refer clients to local drug or alcohol services.

Relapse prevention

Evidence rating: I

There is currently little evidence suggesting which interventions are most likely to prevent people from partially or totally resuming smoking,[138] although research in this area is ongoing. As yet, we are not aware of any published data on relapse rates by time among treated smokers either. Survival rates among the general untreated population, however, are shown in the figure below.



True survival curves (solid lines) and line-graph relapse curves (dotted lines) in self-quitters (open circles and triangles) and those in control groups (solid circles and triangles) taken from Hughes et al.[139]

138 Hajek P, Stead LF, West R, Jarvis M and Lancaster T (2009) 'Relapse prevention interventions for smoking cessation'. *Cochrane Database of Systematic Reviews*, Issue 1, Art. No.: CD003999. DOI: 10.1002/14651858.CD003999.pub3

139 Hughes JR, Keely J and Naud S (2004) 'Shape of the relapse curve and long-term abstinence among untreated smokers'. *Addiction* 99(1):29–38

Repeat service users

Evidence rating: ✓

Smokers often need several attempts before stopping successfully. Anyone who has made a previous, unsuccessful, quit attempt should therefore be offered brief advice on how to stop smoking (see page 33). As the majority of successful quit attempts are unplanned or spontaneous, smokers should also be enabled to stop whenever they want to (see page 98, Time between treatment episodes).[140]

Quit attempts should draw on experiences from previous attempts to stop, and should bear in mind factors that contributed to previous relapses (e.g. high nicotine dependency). Groups with higher rates of smoking, such as those with mental illness, are more likely to be repeat service users, and specific provision should be made to encourage their re-engagement with stop smoking services.

140 Hughes JR and Carpenter MJ (2006) 'Stopping smoking: carpe diem?' *Tobacco Control* 15:415–16

PART 3: MONITORING NHS STOP SMOKING SERVICES

NHS Stop Smoking Services can be monitored monthly, with data submitted to the Department of Health (DH) using the brief reporting system introduced in 2007. Since November 2008, however, this process has been optional and not all strategic health authorities (SHAs) choose to follow it.

Formal data is collected through more detailed, quarterly data collections and is submitted to SHAs, who forward it to the NHS Information Centre (IC) (ROCR/OR/0028/008). In response to the Healthcare Commission's concerns about data quality, changes to the system were introduced in 2008/09. These included the exception reporting system, a new data verification and checking process that is now used by primary care trust (PCT) smoking and clinical governance leads to ensure that the right definitions have been used and that results that fall outside an expected success rate range (derived from smoking cessation literature) are investigated (see below).

At the end of the monitoring period (a quarter plus six weeks), SHAs have a further four weeks to submit data to the IC in the case of Quarters 1 to 3 and five weeks in the case of Quarter 4 data. This means that at the end of the quarter, SHAs have a total of 10 weeks to submit returns in the case of Quarters 1, 2 and 3 and 11 weeks in the case of Quarter 4.

Revisions of previous quarters (to allow for late data) are permitted in the case of Quarters 1, 2 and 3 but **not in the case of Quarter 4** (due to the deadline for the Healthcare Commission's Annual Health Check). Under this system, however, more time is available for submission of Quarter 4 data than for any other quarter. Late data from Quarter 4 may not be carried into Quarter 1 of the next reporting year.

For the first three quarters of the year, the IC produces three sets of tables at national, SHA and PCT levels accompanied by a summary describing key results. Within the Quarter 4 annual report all provisional figures from previous quarters are confirmed and figures are deemed final. Extensive analysis is conducted at this point and a much more comprehensive report is produced.

Table 12: 2009/10 returns timetable

Quarter	End of six-week follow-up period	SHA deadline to submit data to IC and elapsed weeks	Deadline for data collection team to submit data to Lifestyles team and elapsed weeks
April to June	12/08/2009	09/09/2009 (4wks)	16/09/2009 (1wk)
July to September	12/11/2009	10/12/2009 (4wks)	17/12/2009 (1wk)
October to December	12/02/2010	12/03/2010 (4wks)	19/03/2010 (1wk)
January to March	13/05/2010	17/06/2010 (5wks)	24/06/2010 (1wk)

The monitoring and reporting process for 2009/10

There are no substantive changes to the quarterly monitoring and reporting process for 2009/10, although the requirement to submit monthly data on the number of four-week quitters through the UNIFY system ceased in November 2008.

SHAs are welcome to carry on submitting monthly statistics in this way if they find it beneficial, but we know that some SHAs have chosen to opt out. Any data submitted on a monthly basis through UNIFY is therefore only relevant to individual SHAs. No monthly national picture of NHS Stop Smoking Services is available.

'GOLD STANDARD' MONITORING

To encourage greater consistency in the data collected from the stop smoking service network we have devised a 'gold standard' monitoring form (see Annex H). This has recently been amended for the purposes of clarification. To improve consistency, we would urge services to use this form or adapt existing forms to include the same content; for example, when services are ready to reprint stocks of this form, they should use the new double-sided version. An electronic version of the form can be downloaded at www.smokefree.nhs.uk/resources.

Services will already have more detailed client record forms that provide information about each stage of treatment as well as client motivation and quit history. Some PCTs have also invested in web-based information systems to help streamline their data collection

processes and analyse service performance. Such systems can be of great benefit to commissioners and have proved a highly worthwhile investment in a number of areas.

DEFINITIONS AND DATA QUALITY

It is important that we respond to the concerns of the Healthcare Commission. It is therefore essential that all NHS Stop Smoking Services adopt strict criteria when deciding who to include in their monitoring return, and the four-week quit status of a client. These criteria also need to be applied consistently. When recording the numbers of smokers entering treatment and the numbers successfully quit at four weeks, it is essential that all services adhere to the definitions given in Annex D (see page 95).

The purpose of the data monitoring system is to monitor and evaluate the effectiveness and reach of NHS Stop Smoking Services. It is designed to provide consistent information on people who have sought and received quitting help from an evidence-based NHS Stop Smoking Service. **It is not a mechanism for counting all people who have stopped smoking in a locality, nor is it a prevalence measure**. For this reason it should not include quits that have not resulted from structured stop smoking interventions delivered by stop smoking advisers.

ENCOURAGING HONEST SELF-REPORTS

When carrying out four-week quit status checks, it is vital that staff phrase their questions in a way that encourages honest answers. For example: 'Are you sure that you haven't smoked at all in the past two weeks? Not even a puff?' The honesty of client's self-reports may be enhanced by using a multiple-choice question format:

'Which option best describes your smoking activity since your quit date?'

- ☐ I haven't smoked at all since my quit date, not even a puff.
- ☐ I did have the odd puff/cigarette early on in my quit attempt but haven't smoked at all in the last two weeks, not even a puff.
- ☐ I have had the odd cigarette/puff in the last two weeks.
- ☐ I am still smoking but have cut down.
- ☐ I am still smoking as much as before my quit date.

DISABILITY DISCRIMINATION ACT

Amendments to the Disability Discrimination Act (DDA) 1995, which came into force in December 2006, require all NHS authorities to actively promote disability equality and monitor their compliance with it. To ensure compliance with this legal requirement, DH also published a practical guide to help NHS organisations develop disability equality schemes.[141]

141 Department of Health (2008) *Creating a Disability Equality Scheme: A Practical Guide for the NHS.* www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4139666

Exception reporting system

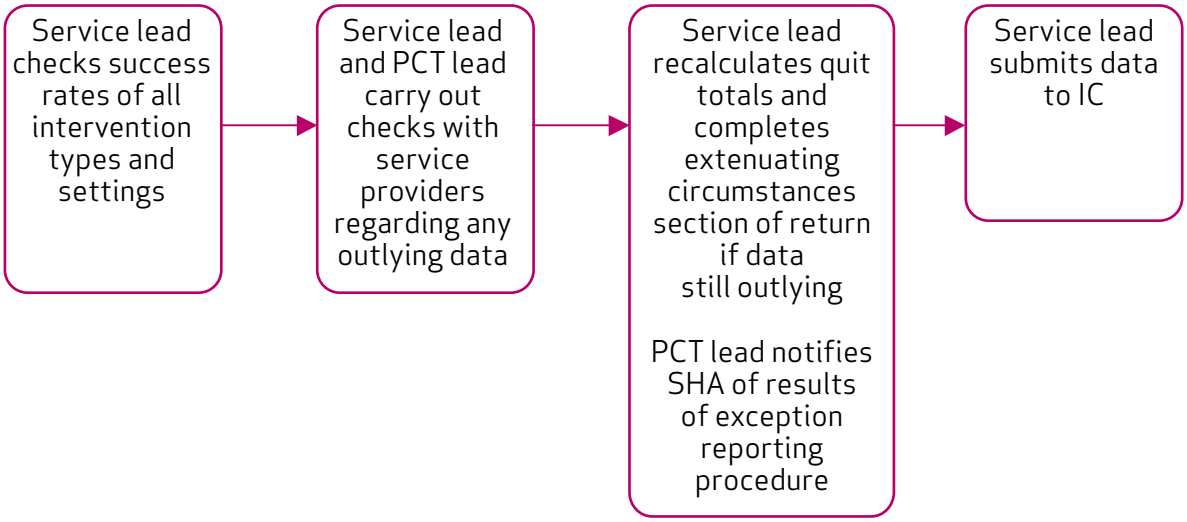
Before submitting quarterly data, service leads should examine their data. If they find outlying data they should carry out the exception reporting procedure. This should be done in co-operation with a PCT clinical governance or data lead. The information lead at the relevant SHA should be notified of the results before data is submitted to the IC.

Results for all intervention types and their settings should be checked by the PCT lead to determine whether all four-week quit rates (self-reported and CO-verified) fall between 35% and 70%. If the overall service results (or those for a specific intervention type/setting) fall outside this range then the following checks should be carried out:

- **The service provider or adviser should be contacted and asked to confirm that all definitions contained within the guidance have been followed**. If this is not the case, then the total number of successful four-week quits should be recalculated using the approved definitions and the data re-entered onto the service database.
- **If the service provider or adviser asserts that the approved definitions have been used, a minimum of three random checks of smokers treated by the service provider or adviser concerned should be carried out** by telephone (or face-to-face if possible). This should establish whether they meet the criteria for self-reported or CO-verified four-week quits at the four-week follow-up point and if they have received an approved intervention of the required content and duration. A minimum of three successful random calls to clients must be made, so if attempts to contact one client fail, another client should be selected. If the random checks indicate that recorded quits are unreliable, all cases received from this provider should be checked using the approved definitions and the total number of four-week quits should be re-entered onto the service database. If, after the required checks have been carried out, the results are still outside the expected range, an assessment should be made of the most likely causes.
- To facilitate service audits and comply with clinical governance requirements, all service providers should maintain adequate client records (to include all client contacts, medications used and smoking status). **Service providers should return data on all clients treated (not just on successful outcomes) so that success rates may be accurately calculated. These requirements should be specified in service level agreements.**

- **Service providers or advisers who repeatedly submit incorrect or incomplete data should receive refresher training in the approved definitions and procedures**. Any data they submit should be subject to regular spot checks until the service lead is satisfied that the correct procedures and definitions are being used. It is especially important to monitor the data supplied by providers who are paid for their work or for successful four-week quit data under a Service Level Agreement (SLA). This will ensure that quitters are receiving the appropriate treatment and that the service is getting value for money.
- **Extenuating circumstances that may clarify otherwise unexplained outlying data should be recorded in the comments box in the exception reporting section of the quarterly return**. If the extenuating circumstances in a given case are not contained within the drop-down menu, the service lead should select 'other' and explain the circumstances using free text.

THE EXCEPTION REPORTING PROCEDURE



ANNEX A: THE SMOKEFREE RESOURCE CENTRE

The Smokefree Resource Centre is a new and improved version of the extranet, available at www.smokefree.nhs.uk/resources. It contains comprehensive links to a wide range of policy, guidance documents and resources relevant to this area.

Designed for HCPs, local service providers, employers and partners, it is much easier to navigate and allows users to search by topic, type and campaign as well as to access regional information. Users can also sign up for updates, including a quarterly newsletter, or set up an account that stores their previous orders.

The site will be reviewed regularly and new resources and functionality will be added throughout 2009. If you have any comments on the new site, please contact **smokingorders@coi.gsi.gov.uk**.

ANNEX B: USEFUL CONTACTS

Your first point of contact should be either your RTPM or, if there is one, the RPM. Communications-related matters should be addressed to the RCM, where in post.

North East

Ailsa Rutter (RTPM) Ailsa.Rutter@freshne.com
Martyn Willmore (RPM) Martyn.Willmore@freshne.com
Andy Lloyd (RCM) Andy.Lloyd@freshne.com

North West

Andrea Crossfield (RTPM) andrea.crossfield@smokefreenorthwest.org.uk
Jane Sunter (RPM) jane.sunter@smokefreenorthwest.org.uk
Pippa Sargent (RCM) pippa.sargent@smokefreenorthwest.org.uk

Yorkshire & Humber

Patricia Hodgson (RTPM) patricia.hodgson@dh.gsi.gov.uk
Madge Boyle (RPM) madge.boyle@dh.gsi.gov.uk
Scott Crosby (RCM) scott.crosby@dh.gsi.gov.uk

West Midlands

Paul Hooper (RTPM) ph7@blueyonder.co.uk
Aaron Bohannon (RPM) aaron.bohannon@gmail.com

East Midlands

Andrew Head (RTPM) andrew.head@dh.gsi.gov.uk

East of England

Beelin Baxter (RTPM) beelin.baxter@dh.gsi.gov.uk

London

Andrew Hayes (RTPM) andrew.hayes@dh.gsi.gov.uk
Ghazaleh Pashmi (Assistant RTPM) ghazaleh.pashmi@dh.gsi.gov.uk
Dominick Nguyen (RCM) dominick.nguyen@dh.gsi.gov.uk

South East

Joanne Locker (RTPM) joanne.locker@dh.gsi.gov.uk
Anita Cameron-Smith (RPM)

South West

Fiona Andrews (RTPM) fiona.andrews@gosw.gsi.gov.uk
Juniper Connal (RPM)
Andrea Dickens (RPM)

National Support Team for Tobacco Control

Tel: 020 7972 3014
Keith Burnett, Delivery Manager
Sarah Wyatt, Delivery Manager
Sarah Edwards, Associate Delivery Manager
Leona Condliffe, Associate Delivery Manager
Gail Addison, Associate Delivery Manager
Clair Harris, Associate Delivery Manager

DH Tobacco Policy Team

Nicky Willis, Team Leader, Supporting Smokers to Stop
Emma Croghan, Smoking Cessation Delivery Manager
Melanie Chambers, Smoking Cessation Delivery Manager

DH Marketing Communications Team

Sarah Haynes, Team Leader
David Prince, Senior Campaign Manager
Stephanie Youell and Louise Kennedy, Campaign Managers

OTHER USEFUL CONTACTS

NHS Stop Smoking Helpline 0800 169 0 169
NHS Pregnancy Smoking Helpline 0800 169 9 169
NHS Asian Tobacco Helplines:

- Urdu 0800 169 0 881
- Punjabi 0800 169 0 882
- Hindi 0800 169 0 883
- Gujarati 0800 169 0 884
- Bengali 0800 169 0 885

Health and Safety Executive 0800 300 363

ANNEX C: USEFUL RESOURCES

The Smokefree Resource Centre www.smokefree.nhs.uk/resources

The Smokefree campaign website (www.nhs.uk/smokefree) has information, tools and video content for smokers who want to quit. Smokers can also look up their local NHS Stop Smoking Service.

Cochrane reviews www.cochrane.org/reviews/

National Institute for Health and Clinical Excellence www.nice.org.uk/

Medicines and Healthcare products Regulatory Agency www.mhra.gov.uk/index.htm

Electronic Medicines Compendium http://emc.medicines.org.uk/

Smoking Cessation Service Research Network www.scsrn.org/

GLOBALink www.globalink.org/

Action on Smoking and Health www.ash.org.uk/

ANNEX D: DEFINITIONS

Bank staff

Staff involved in the delivery of NHS stop smoking interventions who have been trained to HDA standards and who are paid to provide these services outside their normal working hours.

Carbon monoxide-verified four-week quitter

A treated smoker whose CO reading is assessed 28 days from their *quit date* (-3 or + 14 days) and whose CO reading is less than 10ppm. The -3 or +14 day rule allows for cases where it is impossible to carry out a face-to-face follow-up at the normal four-week point (although in most cases it is expected that follow-up will be carried out at four weeks from the quit date). This means that follow-up must occur 25 to 42 days from the quit date (Russell Standard).

Clients whose follow-up date falls outside this timespan may not be counted for the purposes of quarterly data submissions to the IC. CO verification should be conducted face-to-face and carried out for at least 85% of self-reported four-week quitters.

The percentage of CO-verified clients should be calculated as shown below:

$$\frac{\text{Number of treated smokers who self-report continuous abstinence from smoking from day 14 to the four-week follow-up point, and who have a CO reading of less than 10ppm}}{\text{All treated smokers}}$$

Exception reporting system

A data verification and checking system designed to improve data quality and identify the reasons for outlying data (i.e. data that falls outside the expected success rate range derived from the evidence base on smoking cessation).

Monthly monitoring

Voluntary monthly collection and reporting system for which local stop smoking services collect and report data on the numbers of smokers entering treatment and setting a quit date, and the numbers recorded as quit. **This return is now optional** (as of November 2008).

NHS Stop Smoking Service

An NHS Stop Smoking Service is defined as a locally managed, co-ordinated and provided service, funded by DH nationally, to provide accessible, evidence-based, cost-effective clinical services to support smokers who want to stop. Service delivery should be in accordance with the quality principles for clinical and financial management contained within this guidance.

Non-treated smoker

A smoker who receives no support or is given brief or very brief advice and/or supplied with leaflets, helpline cards or pharmacotherapy only, and who does not set a quit date or consent to treatment. Examples may include smokers seen at a health fair or community event, during a GP consultation or during a hospital stay, where a quit date is not set and a quit attempt is not made.

Quarterly dataset

Stop smoking service data that is submitted to the IC on a quarterly basis.

Quit date

Date a smoker plans to stop smoking altogether with support from a stop smoking adviser as part of an NHS-assisted quit attempt.

Renewed quit attempt

A quit attempt that takes place immediately following the end of one treatment episode. A new treatment episode should be commenced in the database/service records.

Routine and manual smoker

A smoker whose self-reported occupational grouping is that of a routine and manual worker, as defined by the NSEC.[142] Smoking prevalence among the R/M socio-economic grouping is significantly higher than among other groupings. This has a major impact on the health and life expectancy of this grouping.

Self-reported four-week quitter

A treated smoker whose quit status at four weeks from their quit date (or within 25 to 42 days of the quit date) has been assessed either face-to-face or by telephone, text, or email

142 Office for National Statistics (2005) *The National Statistics Socio-economic Classification User Manual*

or postal questionnaire. The percentage of self-reported four-week quitters should be calculated as shown below:

$$\frac{\text{Number of treated smokers who self-report continuous abstinence from smoking from day 14 post-quit date to the four-week follow-up point}}{\text{All treated smokers}}$$

Smoked product

Any product that contains tobacco and produces smoke is a smoked product, including cigarettes (hand-rolled or tailor-made), cigars and pipes. Pipes include shisha, hookah, narghile and hubble-bubble pipes.

Smokeless product

There is evidence that the use of smokeless tobacco products (e.g. chewing tobacco, paan, khat etc.) can have negative health effects, including oral cancers. There is some evidence to suggest that behavioural support can be effective.

Note for commissioners

NHS Stop Smoking Services that identify communities within their localities who use such products may wish to develop services to help them to stop, although this relies on the capacity of individual services. Services will also need to consider methods of clinically validating the cessation of smokeless tobacco use. Clients who attend such services are not to be included in data monitoring returns, as the primary aim of NHS Stop Smoking Services is to help people who smoke tobacco to stop smoking, and the purpose of the data monitoring system is to measure the efficacy of the services. To measure efficacy, the number of successful four-week quits submitted is used as the numerator and the number of smokers entering treatment (i.e. treated smokers) the denominator. In light of this, and in line with the treated smoker definition as per the Russell Standard, only those who smoke tobacco should be included in monitoring data submissions.

Smoker

A person who smokes a smoked product. In adulthood this is defined in terms of daily use, whereas in adolescence (i.e. for those aged 16 or under) it is defined in terms of weekly use.

Smoking cessation

In clinical terminology, used to denote activities relating to supporting smokers to stop.

Spontaneous quitters

Smokers who have already stopped smoking when they first come to the attention of the service may be counted as having been 'treated' for local accounting purposes (e.g. to justify resources used or analyse performance) only if they have quit within the 14 days prior to coming to the attention of the service and have attended the first session of a structured multi-session treatment plan within 14 days of their spontaneous quit date (which should be recorded as the quit date).

Services should note that these patients should **not** be included in the data submitted to the national dataset. The results of spontaneous quitters may be recorded for local monitoring only.

Examples of such quitters include clients who experience an unplanned admission to hospital and stop smoking before receiving support, and pregnant smokers who have already stopped smoking before approaching their local NHS Stop Smoking Service or one of the service's trained agents. While it is recognised that it is desirable to offer as many smokers as possible support to quit and maintain abstinence, local commissioners will need to balance the needs of their smoking population against available service resources.

Stop smoking

Preferred term to denote patient-facing communications relating to smoking cessation activity.

Stop smoking adviser

An individual who has received stop smoking service training that meets the published HDA standards[143] for one-to-one and/or group support and is either an NHS Stop Smoking Service core team member or a trained associate of an NHS Stop Smoking Service.

Time between treatment episodes

(see Treatment episode)

When a client has not managed to stop smoking there is no definitive period of time required between the end of a treatment episode and the start of another. The stop smoking adviser should use discretion to professional judgement when considering whether a client is ready to receive support to immediately attempt to stop again. If this is the case, the client must start a new treatment episode, i.e. attend one session of a structured, multi-session intervention, consent to treatment and set a quit date with a stop smoking adviser, in order to be counted as a new data entry on the quarterly return.

143 Health Development Agency (2003) *Standard for training in smoking cessation treatments*. HDA. www.nice.org.uk/aboutnice/whoweare/aboutthehda/hdapublications/standard_for_training_in_smoking_cessation_treatments.jsp

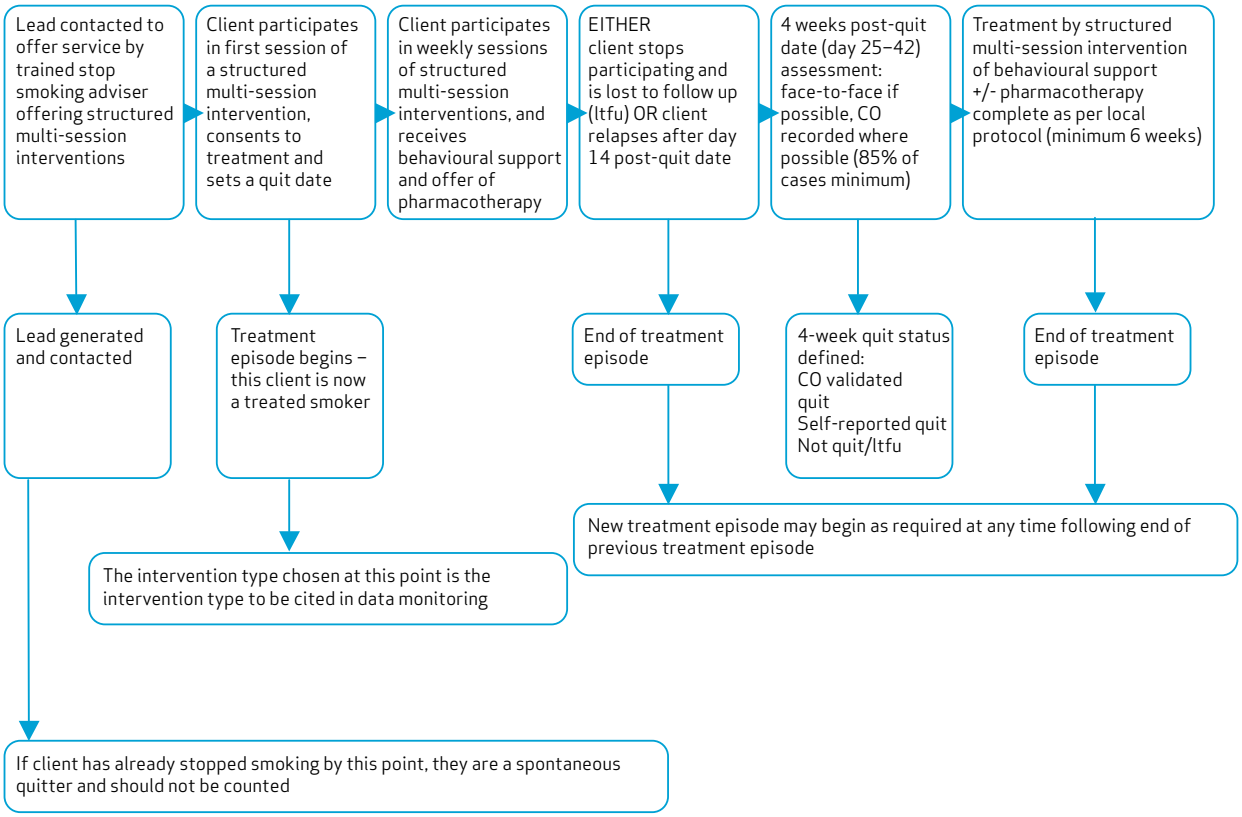
Treated smoker

A smoker who has received at least one session of a structured, multi-session intervention (delivered by a stop smoking adviser) on or prior to the quit date, who consents to treatment and sets a quit date with a stop smoking adviser. Smokers who attend a first session but do not consent to treatment or set a quit date should not be counted.

Treatment episode

At the point of attending one session of a structured, multi-session intervention, consenting to treatment and setting a quit date with a stop smoking adviser, a client becomes a treated smoker and the treatment episode begins. The treatment episode ends when a client either has been completely abstinent for at least the two weeks prior to the four-week follow-up (see flow chart below) or is lost to follow-up at the four-week point, or when a four-week follow-up reveals that a client has lapsed during the two weeks immediately prior to the follow-up and is therefore recorded as a non-quitter. Good practice dictates that if the client wishes to continue treatment after a lapse, treatment should be continued if it seems appropriate, but the client will not count as a four-week quitter for the purposes of that treatment episode.

TREATMENT EPISODE FLOW CHART



ANNEX E: CLIENT SATISFACTION QUESTIONNAIRE

NHS STOP SMOKING SERVICE CLIENT SATISFACTION SURVEY

It is important that NHS Stop Smoking Services know if there is anything that they could do to improve the support that they provide to smokers. Your views about this are very important to us and will be treated in the strictest confidence. The results of this survey will be used for research and service development purposes. **Please answer the following questions as honestly as you can, place the questionnaire in the envelope provided and return the questionnaire to your stop smoking adviser. Thank you.**

Please circle the appropriate number for each question:

1. *Overall, how satisfied are you with the support you have received to stop smoking?*

Very unsatisfied	Unsatisfied	Unsure	Satisfied	Very satisfied
1	2	3	4	5

2. *Would you recommend this service to other smokers who want to stop smoking?*

No	Unsure	Yes
0	1	2

3. *In the event that you started smoking again, would you go back to the service for help with stopping smoking?*

No	Unsure	Yes
0	1	2

4. *If you returned to the service for help with stopping smoking in the future, do you think that you would be welcomed back?*

No	Unsure	Yes
0	1	2

5. *Have you smoked since your last appointment with the service?*

No, not a single puff	Yes, just a few puffs	Yes, 1–5 cigarettes	More than 5 cigarettes
1	2	3	4

6. *Was it easy to contact the stop smoking service when you had decided that you wanted to stop smoking?*

No	Unsure	Yes
0	1	2

7. *When you contacted the stop smoking service, were you given an appointment date or told how long you would have to wait to see someone?*		No 0	Unsure 1	Yes 2
8. *How long did you have to wait before your first appointment/group (please enter number of days in box)?*	..... days			
9. *Was the length of time you had to wait for your first appointment acceptable to you?*		No 0	Unsure 1	Yes 2
10. *Was there contact from the stop smoking service before your appointment to encourage and motivate you to attend treatment?*		No 0	Unsure 1	Yes 2
11. *Are the appointment times you were given convenient for you?*		No 0	Unsure 1	Yes 2
12. *Is the place where you go for your appointments convenient for you to get to?*		No 0	Unsure 1	Yes 2
13. *Have you been offered support with childcare costs?*	Not applicable 4	No 0	Unsure 1	Yes 2
14. *Were you given a choice of an individual appointment or a group?*		No 0	Unsure 1	Yes 2

15. *How satisfied are you with how supportive staff have been?*

Very unsatisfied	Unsatisfied	Unsure	Satisfied	Very satisfied
1	2	3	4	5

16. *How helpful have the information and advice that staff have given to you during your appointment been?*

Very unhelpful	Unhelpful	Unsure	Helpful	Very helpful
1	2	3	4	5

17. How helpful has the written information that staff have given to you been?

None given	Very unhelpful	Unhelpful	Unsure	Helpful	Very helpful
0	1	2	3	4	5

18. Do you find having your carbon monoxide (CO) reading done at every visit helpful?

CO not taken every visit	Very unhelpful	Unhelpful	Unsure	Helpful	Very helpful
0	1	2	3	4	5

19. Was the information that you were given about the choice of medication helpful?

No	Unsure	Yes
0	1	2

20. How did you get your medication?

GP prescription	Chemist (bought myself)	Chemist (with a voucher)	Chemist (with service letter or prescription)	The stop smoking service
1	2	3	4	5

21. Was it easy to get hold of your medication once you had chosen which medication you were going to use for your stop smoking attempt?

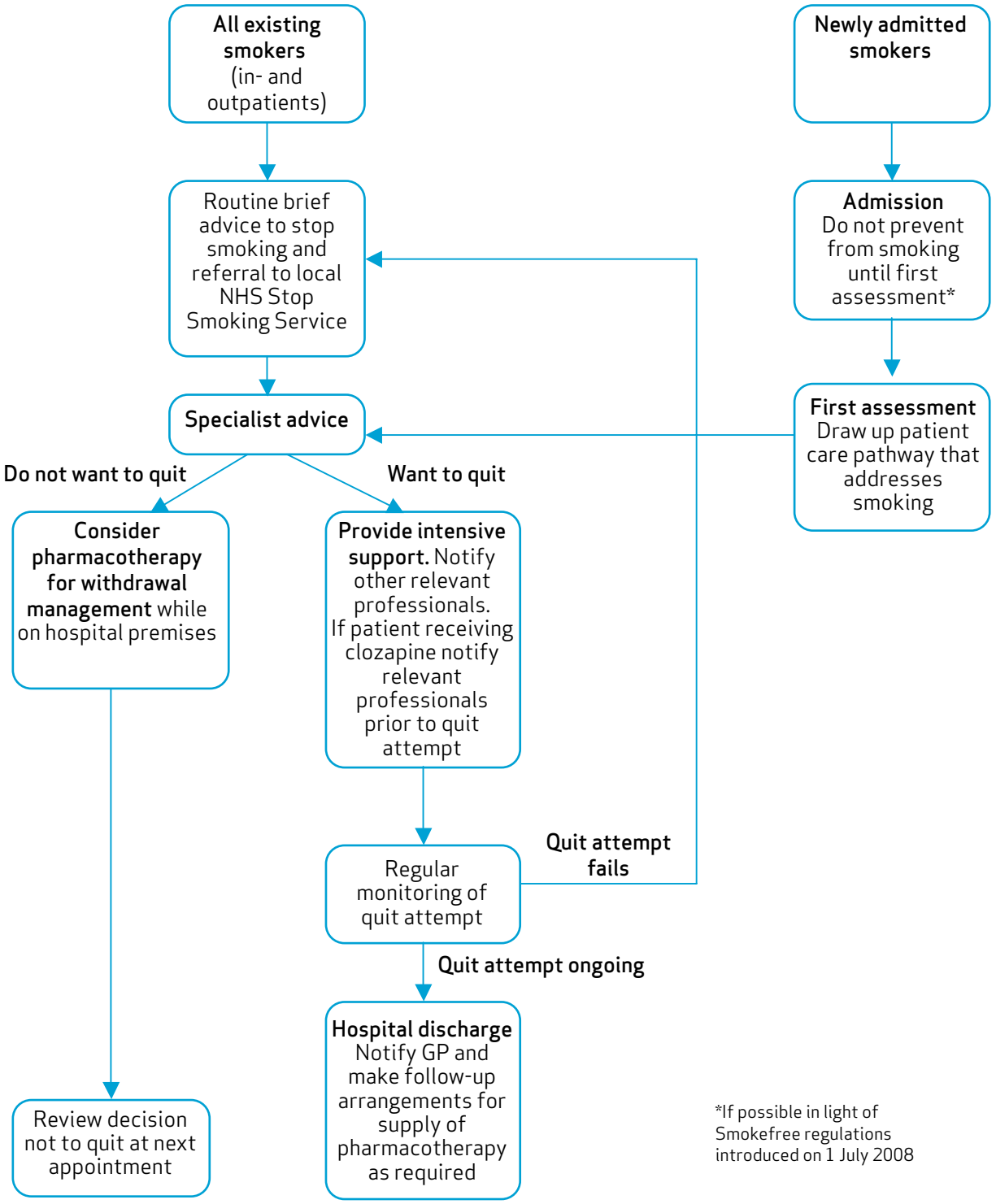
No	Unsure	Yes
0	1	2

If there are any **changes that you would like** to see to the Stop Smoking Service, or if there was anything **they did particularly well**, then please **give details here**:

Now please place the questionnaire in the envelope provided and return it to your stop smoking adviser. Thank you.

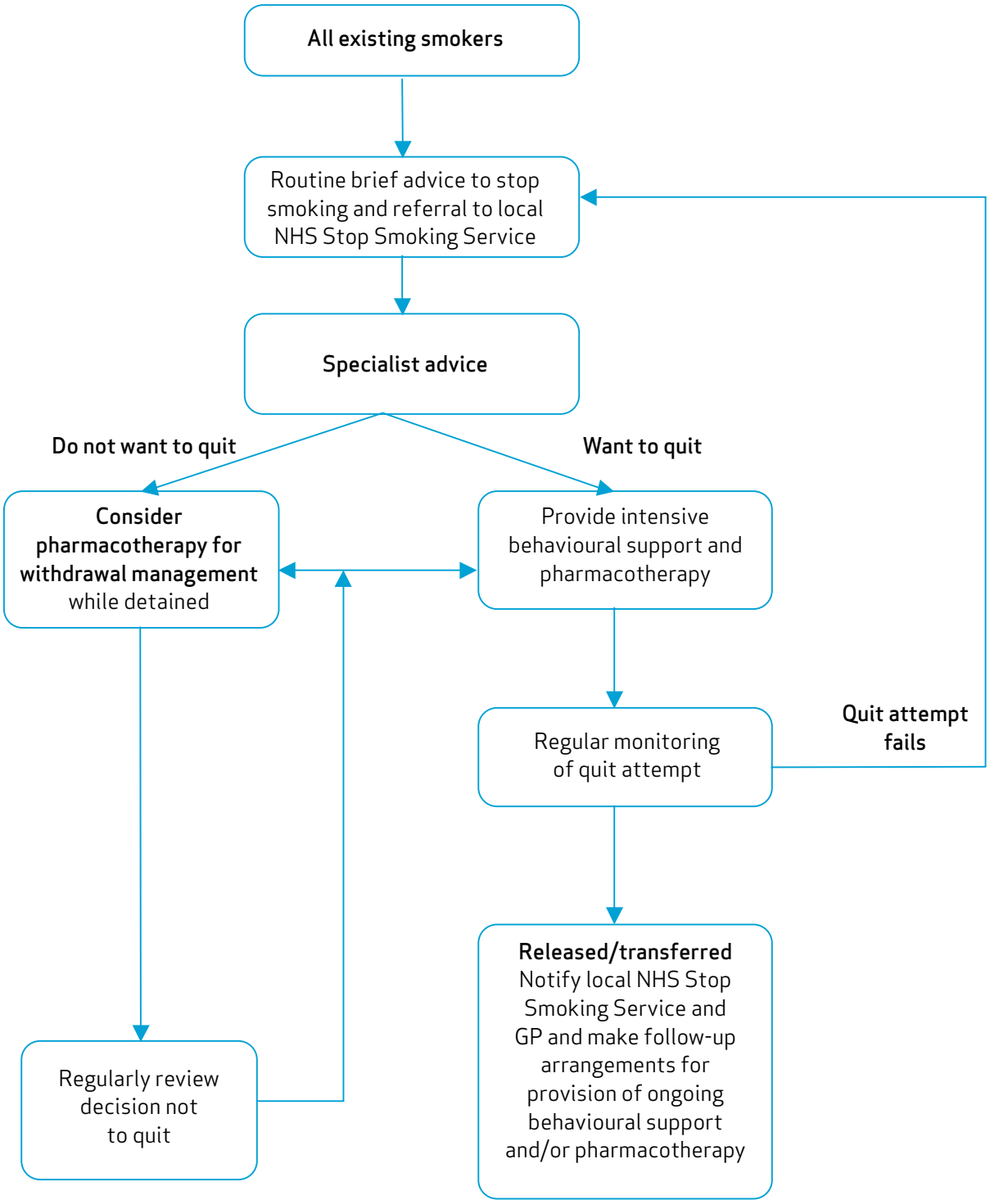
ANNEX F: EXAMPLE CARE PATHWAY – MENTAL HEALTH SETTINGS

(adapted from HDA guidance, 2004)[144]



144 Health Development Agency (2004) *Smoking and patients with mental health problems.* HDA

ANNEX G: EXAMPLE CARE PATHWAY – PRISONS



ANNEX H: GOLD STANDARD MONITORING FORM

(INSERT SERVICE NAME AND ADDRESS) STOP SMOKING SERVICE

Note: All patient data will be kept securely and in accordance with Caldicott guidelines. Information can only be passed to another healthcare professional if this contributes to the provision of effective care.

ADVISER DETAILS:			
Department/Ward		Location/setting	
Name		Venue	
Contact tel. no.		Adviser code/ref	

CLIENT DETAILS:					
Surname		First name		Mr/Mrs/Ms/Other	
Address					
Postcode		NHS ID no.			
Daytime tel. no.		Mobile no.			
Alternative contact number (friend/relative)					
Date of birth		Age (in years)		Gender	Male / Female
Exempt from prescription charge	Y / N	Pregnant	Y / N	Breastfeeding	Y / N

Occupation code *(see reverse for further information)*			
	Full-time student ☐	Never worked/long-term unemployed ☐	Retired ☐
	Home carer ☐	Sick/disabled and unable to work ☐	Managerial/professional ☐
	Intermediate ☐	Routine & manual ☐	Unable to code ☐

ETHNIC GROUP *(please tick relevant group)*

a] White		b] Mixed		c] Asian or Asian British	
British	☐	White and Black Caribbean	☐	Indian	☐
Irish	☐	White and Black African	☐	Pakistani	☐
Other white background	☐	White and Asian	☐	Bangladeshi	☐
		Other mixed groups	☐	Other Asian background	☐
d] Black or Black British		**e] Other ethnic groups**		**f] Other**	
Caribbean	☐	Chinese	☐	Not stated	☐
African	☐	Other ethnic group	☐		
Other Black background	☐				

HOW CLIENT HEARD ABOUT THE SERVICE *(please tick relevant box)*

GP	☐	Friend/relative	☐	Pharmacy	☐
Other health professional	☐	Advertising	☐	Other (please specify)	☐

Agreed quit date		Date of last tobacco use		Date of 4-week follow-up	

TYPE OF INTERVENTION DELIVERED *(for the purpose of data capturing, the intervention type is the one chosen at the point the client sets a quit date and consents to treatment)*

Closed group	☐	Telephone support	☐	Other (please specify)	☐
Open (rolling) group	☐	Couple/family	☐		
One-to-one support	☐	Drop-in clinic	☐		

TYPE OF PHARMACOLOGICAL SUPPORT USED *(please tick all relevant boxes. Use 1 or 2 to indicate consecutive use of more than one medication – e.g. Champix followed by NRT product)*

None	☐	Zyban	☐	NRT – gum	☐
NRT – lozenge	☐	NRT – inhalator	☐	NRT – patch	☐
NRT – microtab	☐	NRT – spray	☐	Champix	☐

TREATMENT OUTCOME

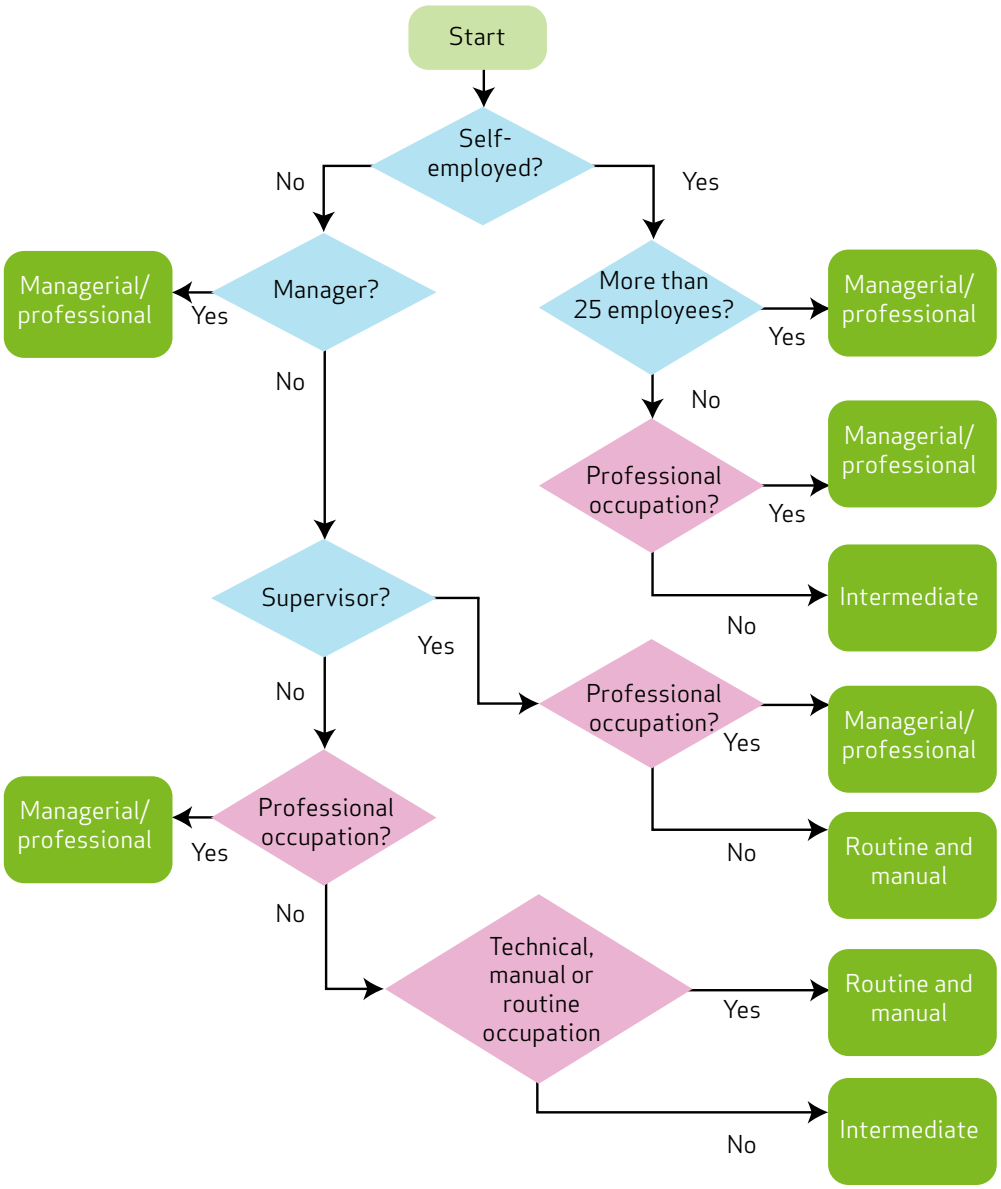
Not quit ☐ Lost to follow-up ☐ Quit self-reported ☐ Quit CO-verified ☐

Adviser signature	Client signature (indicating consent to treatment and pass on of outcome data to GP)

Notes:

1. A client is classified as long term unemployed if they have currently been unemployed for one year or more. If unemployed for less than a year last known occupation should be used for classification.
2. Home carer – i.e. looking after children, family or home.
3. If a client is self-employed please use the flowchart below to determine classification.
4. Supervisor or Foreman is responsible for overseeing the work of other employees on a day to day basis.
5. Managerial and professional occupations, examples include: accountant, artist, civil/mechanical engineer, medical practitioner, musician, nurse, police officer (sergeant or above), physiotherapist, scientist, social worker, software engineer, solicitor, teacher, welfare officer. Those usually responsible for planning, organising and co-ordinating work for finance.
6. Intermediate occupations, examples include: call centre agent, clerical worker, nursing auxiliary, nursery nurse, office clerk, secretary.
7. Routine and Manual occupations, examples include: electrician, fitter, gardener, inspector, plumber, printer, train driver, tool maker, bar staff, caretaker, catering assistant, cleaner, farm worker, HGV driver, labourer, machine operative, mechanic, messenger, packer, porter, postal worker, receptionist, sales assistant, security guard, sewing machinist, van driver, waiter/waitress.

For further assistance in determining socio-economic classifications please see the flowchart below.
If you are still unable to establish a classification, please record as unable to code.



ANNEX I: COMMISSIONING POLICY AND IMPLEMENTATION

The policy framework for commissioning within the wider context of the health reform programme is set out in *Health reform in England: update and commissioning framework*[145] and *Commissioning framework for health and well-being.*[146]

Health reform in England details how the health reform programme is refocusing the NHS to meet the challenges of rising expectations, demographic change, the revolution in medical technology and continuing variations in the safety and quality of care. To address these challenges, we have a clear vision: to develop a patient-led NHS that uses available resources as effectively and fairly as possible to promote health, reduce health inequalities and deliver the best and safest possible healthcare.

The new NHS will not be created in the old way, through command and control. In the next stage of improvement and reform, we need a decisive shift from top-down to bottom-up as we develop a devolved and self-improving health service where the main drivers of change are patients, commissioners and clinicians, rather than national targets and performance management.

This revitalised, patient-led and locally driven NHS is designed to achieve a central goal: dramatically improving the quality of patient care and the value we get from the public money spent on health services.

The *Commissioning framework* sets out a range of measures to strengthen commissioning. These include:

- stronger clinical leadership through practice-based commissioning
- a stronger voice for people and local communities
- better information to underpin commissioning decisions
- new incentives for commissioners to attract new service providers and improve service quality
- more effective levers for commissioners to secure financial stability, including new model contracts
- measures to build commissioning capacity and capability

145 Department of Health (2006) *Health reform in England: update and commissioning framework*. DH. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4137226
146 Department of Health (2007) *Commissioning framework for health and well-being*. DH. www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_072604

The *Commissioning framework for health and well-being* offers guidance for health authorities and LAs in commissioning community healthcare, social care, public health, well-being, and primary care (with the exception of the nationally negotiated GMS contract), as well as other relevant services, support and interventions.

This framework signals a clear commitment to greater choice and innovation, delivered through new partnerships. Its key aims are to achieve:

- a shift towards services that are personal and sensitive to individual need, and that maintain independence and dignity
- a strategic re-orientation towards promoting health and well-being, investing now to reduce future ill health costs
- a stronger focus on commissioning the services and interventions which will achieve better health, across health services and local government, with everyone working together to promote inclusion and tackle health inequalities

Guidance for practice-based, PCT, specialist, joint and LA commissioners has an important role in driving up the quality of care to patients and the public, but guidance is just that. The responsibility for taking decisions about the scope and range of services rests with local commissioners, on the basis of their local needs assessment and evidence of how health gains for their population could most likely be maximised.

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