

# Local Stop Smoking Services

Service and delivery guidance 2014

***NCSCT***



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## Abbreviations

<b>AMD</b>	Age-related macular degeneration
<b>BME</b>	Black and minority ethnic
<b>CCG</b>	Clinical Commissioning Group
<b>CHD</b>	Coronary heart disease
<b>CKD</b>	Chronic kidney disease
<b>CO</b>	Carbon monoxide
<b>CQUIN</b>	Commissioning for Quality and Innovation
<b>COPD</b>	Chronic obstructive pulmonary disease
<b>DH</b>	Department of Health
<b>FTCD</b>	Fagerström test for cigarette dependence
<b>GSL</b>	General sales list
<b>HSCIC</b>	Health and Social Care Information Centre
<b>HSI</b>	Heaviness of smoking index
<b>JHWS</b>	Joint Health and Wellbeing Strategy
<b>JSNA</b>	Joint Strategic Needs Assessment
<b>LTFU</b>	Lost to follow-up
<b>MHRA</b>	Medicines and Healthcare products Regulatory Agency
<b>NARS</b>	Nicotine-Assisted Reduction to Stop
<b>NCSCT</b>	National Centre for Smoking Cessation and Training
<b>NICE</b>	National Institute for Health and Care Excellence
<b>NRT</b>	Nicotine replacement therapy
<b>ONS</b>	Office for National Statistics
<b>PAD</b>	Peripheral artery disease
<b>PbR</b>	Payment by results
<b>PGD</b>	Patient group direction
<b>ppm</b>	parts per million
<b>QOF</b>	Quality and Outcomes Framework
<b>RCT</b>	Randomised controlled trial
<b>R/M</b>	Routine and manual
<b>ROI</b>	Return on investment
<b>SIGN</b>	Scottish Intercollegiate Guidelines Network
<b>SPC</b>	Summary of product characteristics
<b>STS</b>	Smoking Toolkit Study
<b>TIA</b>	Transient ischaemic attack
<b>UKCTAS</b>	UK Centre for Tobacco and Alcohol Studies
<b>VBA</b>	Very brief advice

Key terms can be found in the definitions section in Annex B (see page 90). The research on which this guidance is based is fully referenced throughout.

## Executive summary

- The provision of a high-quality stop smoking service is a high priority for reducing health inequalities and improving the health of local populations
- Stop smoking services are extremely cost-effective and form a key part of tobacco control and health inequalities policies at both local and national levels;<sup>1</sup> this should be reflected in effective local commissioning
- All health and social care services play a key role in identifying smokers and referring people to stop smoking services; referral opportunities need to be maximised
- In line with National Institute for Health and Clinical Excellence (NICE) best practice recommendations, service providers should aim to treat at least 5% of their local smoking population<sup>2</sup>
- Services are most effective when configured according to local need and informed by the local Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS)
- Groups that are known to experience a high smoking prevalence or require specific targeting include routine and manual workers, people with mental health disorders (including alcohol and substance use), prisoners, LGBT communities, the homeless and certain black and minority ethnic groups. These and other groups such as pregnant smokers may benefit from interventions that address specific needs

## Delivering support

- Service design and delivery should be informed by the latest evidence base, summarised in this document and in NICE guidance
- Offering all licensed stop smoking medicines as first-line interventions, including varenicline and combination NRT, will maximise success
- Health and social care professionals who assist smokers to quit, including all stop smoking practitioners, should achieve certification through the National Centre for Smoking Cessation and Training<sup>a</sup>
- Services can provide behavioural support to clients wishing to use unlicensed nicotine containing products (such as e-cigarettes<sup>b</sup>), and where this activity conforms to the Russell Standard it can be reported as part of the national data set

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a [www.ncsct.co.uk](http://www.ncsct.co.uk)

b Throughout this document, those products, commonly known as electronic cigarettes, will be referred to as nicotine vapourisers, as this name more accurately reflects their use as nicotine delivery devices.

- Areas may also wish to provide support to clients who are no longer smoking tobacco but who would like help to stop their use of e-cigarettes (nicotine vapourisers). However, this is a local policy matter and there is no national expectation that services will provide this type of support
- Smokers who make multiple attempts to quit before achieving long-term success should be supported with increasingly intensive interventions. Repeatedly delivering the same intervention that has led to previous poor outcomes is not a good use of resources

To achieve best practice, all service delivery models should conform to established intervention principles (see page 29).

### Measuring success

- Four-week quits remain the national outcome measure for stop smoking services, and it is strongly recommended that local areas continue to collect and submit this data. If they wish, areas may also measure longer-term outcomes and quality measures such as customer satisfaction
- Smokers attempting to stop without additional support generally have a success rate of 25% at four weeks (for carbon monoxide (CO) validated quits) and a success rate of about 35% at four weeks (for self-reported quits). Therefore to show an impact, services must achieve success rates in excess of these
- At least 85% of four-week quits should be CO verified and other outcomes measured locally should be validated where possible
- Where four-week success rates fall outside a 35%–70% range, then it is recommended that an 'exception-reporting procedure' is adopted to check adherence to the intervention principles (see Annex B, page 90, for data definitions)
- It is also recommended that services have quality assurance procedures in place to ensure the quality of the service being provided; this should include an element of independent auditing to complement internal checks

## Introduction

Smoking remains the leading cause of preventable death and disease in England,<sup>3</sup> and is one of the most significant factors that impacts upon health inequalities and ill health, particularly cancer, coronary heart disease and respiratory disease. Treating smoking-related illness is estimated to cost the NHS £2.7bn a year,<sup>4</sup> with the wider economic costs reaching over £13bn once factors such as lost productivity, tobacco litter and smoking-related house fires are taken into account.<sup>5</sup> Reducing smoking prevalence therefore remains a key local public health priority and a national focus.<sup>6</sup>

Stop smoking services should not be regarded as the main driver for reducing smoking prevalence, which is affected to a much greater degree by national policy and broader local tobacco control strategies. However, stop smoking service providers should sit within an overall tobacco control programme and should form part of a wider action to reduce local smoking prevalence.<sup>1</sup> A network of stop smoking services has existed in England since 1999. These services are proven to be highly cost-effective and have been shown to effectively assist in reducing the health inequality caused by smoking.<sup>7,8</sup>

An effective way of reducing the rate of children and young people taking up smoking is to support adult smokers to stop, and therefore high-quality, evidence-based services will also contribute to preventing the initiation of smoking.



### Stop smoking service activity

The number of smokers accessing services nationally had generally been increasing year on year; but data published for the past two years has shown a significant overall reduction. In 2013–14, 19% fewer people set quit dates through stop smoking services across England compared to in 2012–13, which itself suffered a drop of 11% compared with 2011–12.<sup>9</sup> Given that services offer smokers a significantly higher chance of stopping smoking compared with trying to quit without support or medication, a reduction in throughput would be of concern should this trend continue.

Although the reasons for the downturn are unknown, there are a number of factors which may have had a part to play, including a change in the formulation of national mass media messages (from directly encouraging access to stop smoking services to promoting population-level quit attempts, e.g. Stoptober, Health Harms and Quit Kits); an overall reduction in the quantity and duration of advertising and publicity at a national level; and the impact of the transition of public health to local authorities and changes in commissioning arrangements for stop smoking services that may have included a reduction in local budgets for both services and promotional activity. In addition, the increasing use of nicotine vapourisers (e-cigarettes) by smokers who are trying to either stop or cut down is likely to have had an impact. It is important to continue to track stop smoking service activity and it is particularly important that local areas continue to submit quarterly and annual data to the Health and Social Care Information Centre (HSCIC).

Despite this downturn, overall self-reported four-week success rates were 51% for 2013–14, which is similar to rates in 2012–13 (52%) and higher than for 2011–12 (49%), suggesting that the quality of interventions being provided is being maintained.

### Role of stop smoking services

Following the transition of responsibility for public health from primary care trusts to local authorities, the role of stop smoking services is coming under increasing scrutiny and the idea of developing broader 'lifestyle' services is becoming more popular. Currently, evidence indicates that generic lifestyle services are not as effective at achieving behaviour change as services devoted to specific behaviours.<sup>10</sup> It is therefore important that any proposed changes to services do not undermine existing, effective smoking cessation support.

Evidence and best practice, as reflected in this document, recognise stop smoking services as specific, stand-alone public health services.

### This document

This document provides an overview of the latest evidence relating to the commissioning, delivery and monitoring of stop smoking services to support effective local planning. In addition, best practice guidance is provided for both service commissioners and providers. Guidance regarding the implementation of specific harm reduction interventions is not provided, although a separate commentary on harm reduction is provided in Annex I.

# PART 1: COMMISSIONING SERVICES

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## 1. Stop smoking services

Stop smoking services are now well established and have had a significant impact on helping smokers to stop<sup>11</sup> and on the creation of a large number of permanent ex-smokers. It is estimated that in 2012–13 over 36,000 premature deaths were prevented by these services.<sup>12</sup>

The primary role of stop smoking services is to deliver high-quality, evidence-based stop smoking interventions to their local population. In the main, services are currently commissioned to deliver an abrupt cessation model, supporting a smoker who is motivated to stop to set a quit date immediately or in the very near future, after which they smoke not one puff on a cigarette (see *Treated smoker* definition, page 92). The support programme offered by services involves a combination of behavioural support and licensed pharmacotherapy.

NICE guidance, including harm reduction guidance (see Annex I), identifies an abrupt approach to stopping smoking (or quitting in one step) as the most effective and recommends that this should remain the core function of local stop smoking services.

Services are not a main driver for reducing smoking prevalence; national policy and local tobacco control strategies are more able to achieve this. However, stop smoking service providers should sit within an overall tobacco control programme and should form part of a wider action to reduce local smoking prevalence.<sup>1</sup> As services provide the best chances of quitting for an individual, they can also make significant contributions to reducing health inequalities,<sup>1,7</sup> particularly when delivered to populations in which smoking prevalence is high.

In a given year, services should aim to treat at least 5% of their local population of smokers, in line with best practice recommendations contained within NICE guidance for smoking cessation.<sup>2</sup>

Effective stop smoking commissioning considers the entire pathway that smokers follow, starting with service promotion and engagement, providing support to quit and ongoing support and relapse prevention, and concluding with follow-up and re-engagement. The remainder of this section provides information and best practice guidance to assist this process.

## 2. Information and intelligence

Local intelligence has a vital role to play in commissioning plans. Services, and types of intervention, that are configured according to local needs will make a greater contribution to reducing inequalities than those delivered without this understanding. The key to ensuring that services are aligned with the needs of the local population lies in a comprehensive local health needs assessment that is included within the local Joint Strategic Needs Assessment (JSNA) (see [www.hscic.gov.uk/jsna](http://www.hscic.gov.uk/jsna)) and the Joint Health and Wellbeing Strategy (JHWS).

The local tobacco profiles available via [www.tobaccoprofiles.info](http://www.tobaccoprofiles.info) include data that can be used to illustrate the impact of services by local authority area. The profiles also include data from the Integrated Household Survey, which is used to track national smoking prevalence.

Local data systems support accurate recording and reporting of stop smoking service provision, and can be used to inform and improve both the local commissioning and the local provision of services. Increasingly, areas have implemented web-based databases that can be locally modified to record a range of information in addition to the mandatory data fields, e.g. information about access by high-risk service user groups and their cessation rates. An example of a comprehensive monitoring form is provided in Annex H.

In order to help monitor and evaluate the national effectiveness and reach of local stop smoking services, it is important that local areas continue to submit quarterly data to the Health and Social Care Information Centre (HSCIC). Submission of this data supports research and informs the provision of national support to assist local delivery (see Part 3, pages 80–84). Continuing to submit this data also offers further direct benefits for local areas, as listed below.

### Advantages of continued national data reporting

- Inclusion of data in the NICE ROI tool: the data returns are included in the NICE ROI tool; non-submission of data would limit the usefulness of the tool for local authorities
- Informing commissioning plans: the data returns underpin the development and scrutiny of robust JSNAs and JHWSs and provide information for the annual report of the Director of Public Health
- Monitoring commissioned services: the returns provide essential data for monitoring the delivery of commissioned public health services and help support sector-led improvement
- Benchmarking and assessing comparative outcomes: maintaining complete national coverage of the data returns is essential to enable all councils to undertake both national benchmarking and peer group comparisons

### 3. Identification and referral of smokers

Over two-thirds of smokers report wanting to stop, and just over 35% of these intend to make a quit attempt soon.<sup>13</sup> The latest data from the Smoking Toolkit Study (STS) shows that the vast majority of smokers attempting to stop choose the least effective methods of doing so, with less than 5% using the most effective method: their local stop smoking service.

In line with the Making Every Contact Count agenda,<sup>c</sup> systematic identification of smokers and delivery of very brief advice (VBA) by health or social care professionals at every opportunity is required to ensure that smokers access the most effective stop smoking support options available.

#### Key points

- Smoking cessation has been linked to the potential for teachable moments,<sup>14</sup> meaning that all health and social care professionals (HSCPs) can have a positive impact on a smoker's decision to stop
- Regardless of any expressed desire to stop, all smokers should be informed that the best way to stop is through a combination of behavioural support and medication, that the best place to receive this is from their local stop smoking service and that a referral can be made there and then
- The systematic provision of very brief advice (VBA) and routine referral of smokers to stop smoking service providers should be written into all provider contracts and supported by appropriate training<sup>d</sup> and established formal referral systems
- All local HSCPs (e.g. practice nurses, district nurses, midwives and health visitors) and social care professionals should be aware of the VBA model for the provision of very brief advice (Ask, Advise, Act) and routinely refer smokers to local stop smoking service providers (see pages 43–45)
- Formalised referral systems, electronic or otherwise, enable the monitoring of referral sources (i.e. settings) and the identification of areas in which referral rates could be improved
- It is not recommended that service providers are remunerated for referrals beyond what is provided through established reward and incentive programmes such as the Quality Outcomes Framework

c See: [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/216423/dh\\_132114.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216423/dh_132114.pdf)

d A free online VBA training programme is available at: <http://elearning.ncsct.co.uk/vba-launch>

## Referral sources

### NHS / public health workforce

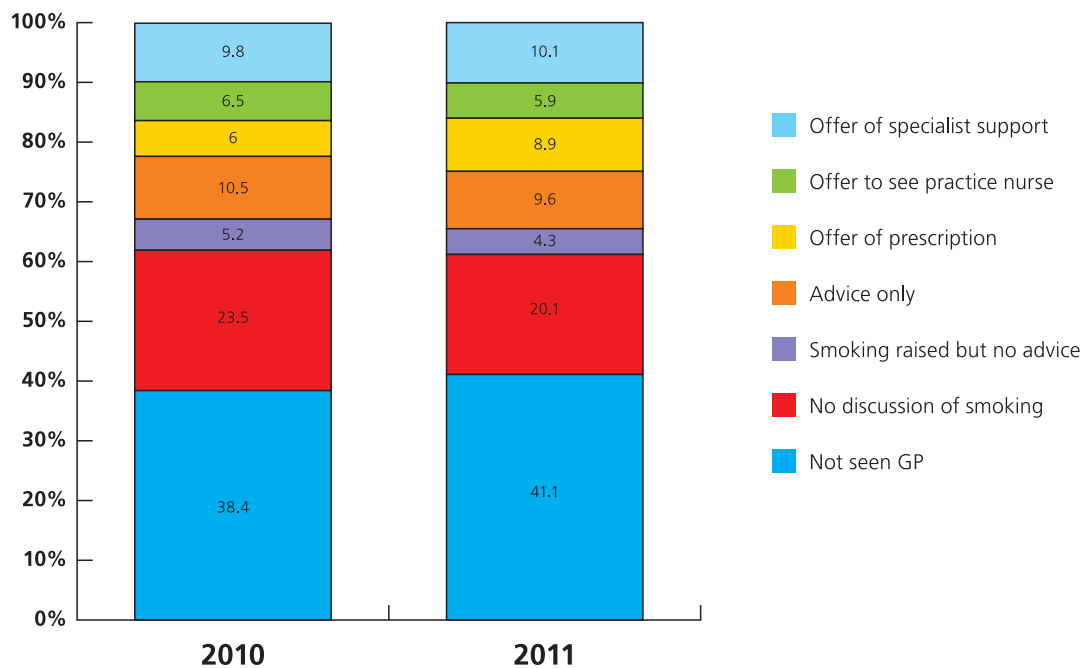
A Department of Health-initiated NHS Health and Wellbeing review reported that just over a fifth of NHS employees smoked and that these staff were more frequently absent from work, or presented to work whilst unwell.<sup>15</sup> Whilst the data available on staff smoking in the NHS and local government is limited, it is important to ensure that staff are supported to access stop smoking services. Staff who have a positive experience of quitting with the help of services may be more likely to recommend these services to others.

### Clinical Commissioning Groups (CCGs) and general practice

GP practice teams have daily contact with a significant number of smokers and therefore play a key role in any local referral network. Most smokers see their GP at least once in any given year. Whilst some practices are very proactive in this area, the STS<sup>13</sup> indicates that the delivery of effective very brief advice is not currently systematic or standardised. Figure 1 shows that the vast majority of smokers either receive no intervention from their GP or ineffective ones; the top three sections in the bars indicate VBA.

It is also useful to note that smoking rates amongst patients with severe mental illness and maternal smoking at delivery are included as measures in the 2014/15 CCG Outcome Indicator Set (see [www.england.nhs.uk/ccg-ois](http://www.england.nhs.uk/ccg-ois)).

**Figure 1: Smokers reports (%) of contact with, advice from or support offered by their GP**



**Note:** Whilst the questions asked in the study all relate specifically to GP activity, very brief advice should form part of routine care delivered by all staff

## Pharmacy

As community pharmacies are frequently people's first point of contact with health services, seeing over 1.6 million people per day, they are a valuable setting for referring and/or supporting smokers who want to stop. Pharmacies are often a key healthcare facility located in areas of high deprivation and so can play a vital role in improving the health of specific communities. Many pharmacies are taking on a greater role in this as part of the Healthy Living Pharmacy programme (see [www.npa.co.uk/business-management/service-development-opportunities/healthy-living-pharmacy](http://www.npa.co.uk/business-management/service-development-opportunities/healthy-living-pharmacy)).

## Dentistry

Over 60% of the adult population in England visits a dentist for regular check-ups, and dental teams also have regular contact with pregnant women and teenagers. This puts them in a strong position to deliver very brief advice and refer smokers to their local stop smoking service provider. In addition to identifying smokers, dentists are also ideally placed to identify users of smokeless tobacco. Further recommendations for helping dental patients quit tobacco are available (see [www.gov.uk/government/publications/smokefree-and-smiling](http://www.gov.uk/government/publications/smokefree-and-smiling)).

## Optometry

There is a strong association between smoking and age-related macular degeneration (AMD). Currently there is no effective treatment for any type of AMD, and identifying modifiable risk factors is of great importance.<sup>16</sup> Optometrists therefore provide a further opportunity to deliver very brief advice to smokers.<sup>17</sup>

## Maternity services

Maternity services play a key role in identifying and referring pregnant smokers or women who smoke and are trying to conceive. NICE guidance<sup>12,18</sup> recommends that a wide range of HSCPs, particularly those within maternity services, proactively identify and refer all smokers to a stop smoking service. Referrals should be made as early as possible and include partners and significant others (see page 64).

## Secondary care

A smoker is more likely to experience post-operative complications and slower wound healing,<sup>19</sup> which could result in the need for further surgery, a longer hospital stay and increased costs to the health service. Admission to hospital has been shown to increase motivation to stop smoking. A Cochrane review found that the offer of support to stop smoking as part of inpatient activity, including community follow-up for at least four weeks post-discharge, improved abstinence rates significantly.<sup>20</sup>

Both primary and secondary care staff can play a pivotal role in the early identification and referral of smokers who have planned admissions, and this activity should be embedded within the pre-operative assessment process. In the case of unplanned admissions, patients must be started on withdrawal-oriented management programmes as early as possible and routinely offered a referral to a stop smoking service. It is crucial that the hospital pharmacy is engaged so that it is able to deliver very brief advice and act as a referrer, as well as ensuring access to stop smoking medicines.

### Mental health and alcohol and substance misuse services

Those with a mental disorder (which includes those with mental illness or alcohol problems or substance misuse problems) have significantly higher smoking rates than the general population and are responsible for 42% of tobacco consumption in the UK.<sup>21</sup>

**Table 1: Percentage of population in England with different mental disorder and rates of smoking**

	Prevalence of disorder in population	Proportion who are regular smokers
<b>Any mental disorder</b>	23%	33%
<b>Common mental disorder</b>	16%	32%
<b>Depressive episode</b>	3%	37%
<b>Phobias</b>	2%	37%
<b>Generalised anxiety disorder</b>	4%	36%
<b>PTSD screen</b>	3%	37%
<b>ADHD screen</b>	1%	31%
<b>Psychosis</b>	1%	40%
<b>Suicide attempt in past year</b>	1%	57%
<b>Drug dependence</b>	3%	69%
<b>Alcohol dependence</b>	6%	46%
<b>Alcohol problems</b>	24%	30%

Mental health problems are a significant risk factor in the uptake of smoking in children and adolescents, with uptake of smoking being six times more common in those with a conduct disorder and four times more common in those with an emotional disorder.<sup>22</sup>

Since the majority of people with a mental disorder are managed in primary care, it is important that primary care pathways are developed and implemented to facilitate improved access to stop smoking support for both adolescents and adults. Since around 70% of adults in mental health units smoke,<sup>23</sup> inpatient and community mental health services, including substance and alcohol services, are well placed to refer people to, or directly provide, stop smoking services.

It is often thought that people with a mental health disorder, those with co-morbidities and those who are polysubstance users are incapable of stopping smoking until they have addressed their other problems. This view is challenged by recent research<sup>24</sup> showing that smoking cessation can improve mental health significantly compared with continuing to smoke; this effect appears to be as great for those with psychiatric disorders as for those without.

To support the delivery of VBA in mental health services, the NCSCT has developed a briefing that is available via the NCSCT website (see [www.ncsct.co.uk/publication\\_Smoking\\_cessation\\_and\\_Mental\\_Health\\_briefing.php](http://www.ncsct.co.uk/publication_Smoking_cessation_and_Mental_Health_briefing.php)).



### **NICE guidance: PH48 Smoking cessation in secondary care: acute, maternity and mental health services**

The National Institute for Health and Care Excellence (NICE) public health guidance (PH48) identifies best practice to support the delivery of stop smoking activities in acute, maternity and mental health services, including community services, drug and alcohol services, and outpatient and pre-admission clinics.

The full guidance can be accessed here: <http://guidance.nice.org.uk/PH48>

### **LGBT communities**

Smoking prevalence data concerning lesbian, gay, bisexual and transgender (LGBT) communities is currently not routinely collected. Previous survey data has shown that gay and bisexual men, lesbians and bisexual women start smoking earlier, smoke more and smoke for longer than their heterosexual counterparts.<sup>25</sup>

Factors that may contribute to higher smoking rates include stress, more frequent socialisation with other smokers and higher rates of alcohol and drug use. Smoking amongst LGBT youth is also associated with social desirability, ready access to cigarettes, risk-taking and rebelliousness, feelings of being unsupported, low self-esteem, negative mood and other mental health factors.<sup>26</sup>

LGBT communities often fear and face discrimination when accessing health services<sup>27,28</sup> and are unlikely to use smoking cessation services that are considered to be generic,<sup>29</sup> preferring to seek specifically targeted services instead.<sup>30,26</sup>

Creating effective links with existing LGBT community groups and outreach services as well as specialist drug and alcohol, mental health and HIV treatment services to support awareness raising, sharing of information and providing access to stop smoke support is recommended.

A strategic framework focused on improving health and wellbeing within LGBT communities is planned for publication by Public Health England later this year. PHE's initial findings on the health and wellbeing of gay, bisexual and other men who have sex with men can be accessed here: [www.gov.uk/government/publications/promoting-the-health-and-wellbeing-of-gay-bisexual-and-other-men-who-have-sex-with-men](http://www.gov.uk/government/publications/promoting-the-health-and-wellbeing-of-gay-bisexual-and-other-men-who-have-sex-with-men)

## Long-term conditions

The Department of Health defines a long-term condition (LTC) as one that cannot, at present, be cured by medication or other therapies. Such conditions include, although are not limited to, chronic obstructive pulmonary disease (COPD), diabetes, coronary heart disease (CHD), asthma, depression and HIV/AIDS.

It is estimated that 15.4 million people in England have a LTC, with 50% of all GP appointments and 70% of hospital bed days used to treat patients with LTCs.<sup>31</sup>

Smoking rates amongst patients with LTCs are often higher than those of the general population and, in many cases, smoking has directly contributed to the development of an LTC. For example, smoking is the largest cause of COPD and continued smoking is known to accelerate disease progression, worsen outcomes and increase the risk of future complications.

Despite this, however, only a small proportion of people with an LTC receive stop smoking interventions. Systematic identification and referral pathways between NHS England, hospital trusts, CCGs and stop smoking services should therefore be established.

## Other settings

### Prison settings

Prisons are an important source of referrals, with up to 80% of the prison population being smokers;<sup>32</sup> there are high rates of mental disorder, and alcohol and drug use are also reported. As the commissioning of health services within prisons is the responsibility of NHS England, it is important that effective partnerships with local authorities are formed so that the best use of local resources is realised. As a minimum, smoking status should be routinely checked as part of the induction process, VBA should be delivered as part of routine health checks and referral to a stop smoking service provided where appropriate (see page 43). Harm reduction interventions could be made available to those people who are, for whatever reason, unable or unwilling to stop smoking in one step. Considering the mobility of this population, care pathways should be introduced that ensure continuity of care throughout the system.

### Health trainers or similar local services

Health trainers or similar local services are ideally placed to refer clients who smoke and who identify stopping as a key priority. All health trainers should therefore be trained to deliver VBA (see page 43) and be aware of local stop smoking service providers and locally agreed referral procedures.

### Partnerships

Commissioners are encouraged to develop and maintain partnerships with a range of organisations to aid service promotion and increase referral opportunities (e.g. workplaces, children centres and the fire service).

## Referral systems

The following systems can all be used to drive referrals of smokers into evidence-based stop smoking services.

### Health checks

The NHS Health Check is a national risk assessment and prevention programme for people aged between 40 and 74 years of age to identify anyone at risk of heart disease, stroke, kidney disease, diabetes and certain types of dementia. Following assessment, anyone identified as at risk should receive advice on achieving and maintaining a healthy lifestyle, including advice about stopping smoking if relevant.

Local councils are responsible for commissioning and monitoring this programme, which provides an ideal referral mechanism for transferral into local commissioned stop smoking services.

Further information about health checks is available from the NHS Health Check website (see [www.healthcheck.nhs.uk](http://www.healthcheck.nhs.uk)).

### Quality and Outcomes Framework (QOF)

The QOF is an annual reward and incentive programme for all GP practices in England and forms part of GP contracts. Although participation by practices in QOF is voluntary, participation rates remain very high. The objective of QOF is to improve the quality of care patients receive by rewarding general practices for the quality of interventions that they provide. It is not, however, a performance management tool. One of the key principles of QOF is that indicators should, where possible, be based on the best available research evidence.

The following indicators relating to smoking are currently part of QOF:

<b>AST004</b>	The percentage of patients with asthma aged 14 or over and who have not attained the age of 20, on the register, in whom there is a record of smoking status in the preceding 12 months
<b>SMOK002</b>	The percentage of patients with any, or any combination of, the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months
<b>SMOK003</b>	The contractor supports patients who smoke in stopping smoking by a strategy which includes providing literature and offering appropriate therapy
<b>SMOK004</b>	The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 24 months
<b>SMOK005</b>	The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 12 months

### Commissioning for Quality and Innovation (CQUIN)

The Commissioning for Quality and Innovation (CQUIN) framework is intended to support improvements in the quality of services and the creation of new, improved, sustainable patterns of care over and above the baseline requirements set out in the NHS Standard Contract.

CQUINs are the responsibility of CCGs and so negotiation will be required if local authorities wish to implement public health-related indicators. CCGs are free to develop and agree local indicators and NHS England has provided a 'pick list' to support commissioners in doing this (see [www.england.nhs.uk/nhs-standard-contract](http://www.england.nhs.uk/nhs-standard-contract)) that includes a reference to supporting COPD patients and pregnant women who smoke.

Smoking is also already included in a national CQUIN applicable to mental health providers, as outlined below.

#### **CQUIN: Improving physical healthcare to reduce premature mortality in people with severe mental illness (SMI)**

Indicator 1: 65% of funding for demonstrating, through a national audit process similar to the National Audit of Schizophrenia, full implementation of appropriate processes for assessing, documenting and acting on cardio-metabolic risk factors in patients with psychoses, including schizophrenia.

The following cardio-metabolic parameters (similar to the 'Lester tool' and the cardiovascular outcome framework) are assessed:

- Smoking status
- Lifestyle (including exercise, diet, alcohol and drugs)
- Body Mass Index
- Blood pressure
- Glucose regulation (HbA1c or fasting glucose or random glucose as appropriate)
- Blood lipids

The results are recorded in the patient's notes/care plan/discharge documentation as appropriate, together with a record of associated interventions according to NICE guidelines or an onward referral to another clinician is made for assessment, diagnosis or treatment, e.g. smoking cessation programme, lifestyle advice and medication review.

## 4. Communications and marketing

### Getting the message across

There is evidence globally to show that marketing and mass media campaigns are effective in prompting quit attempts and reducing smoking prevalence.<sup>33,34</sup>

The latest Smokefree marketing communications strategy was published in spring 2012 (see <http://resources.smokefree.nhs.uk/news/new-marketing-strategy/>) and sets the direction for Smokefree marketing activity until 2015. A new Public Health England Marketing Strategy for 2014 to 2017 was published in summer 2014 which provides a further update on the Smokefree marketing campaigns (see [www.gov.uk/government/publications/public-health-england-marketing-strategy-2014-to-2017](http://www.gov.uk/government/publications/public-health-england-marketing-strategy-2014-to-2017)).

The innovative Smokefree marketing programme has included Smokefree homes and cars, Stoptober and Health Harms, including 'Mutation' and 'Toxic Cycle'. Campaign histories and results are published by the Smokefree Resource Centre (see <http://resources.smokefree.nhs.uk/campaign/>).

Marketing of support services and products is a key offering from Smokefree that is aimed at reinforcing the decision to quit, maintaining motivation and supporting the quitting process; the use of stop smoking services is always recommended when smokers sign up for support (see <https://quitnow.smokefree.nhs.uk/>).

### Local marketing activity

It is recommended that strategies for promoting local services are supported by research and based on local intelligence, including that found within the JSNA. Extensive research exists at a national level (e.g. on routine and manual groups and other audiences), key insights into which are included in the latest national Smokefree strategy.<sup>e</sup>

Where possible, any local communications activity should be integrated with regional and national campaigns to enhance its effectiveness and avoid duplication.

Local marketing initiatives can add most value by:

- Improving understanding of what local services can offer and where help is available
- Triggering quit attempts amongst local smokers and signposting them to local stop smoking services
- Signposting smokers to the most effective support to help them in their quit attempt

To help support local marketing, a toolkit of creative resources is available from the Smokefree Resources Centre (see Annex D).

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e <http://resources.smokefree.nhs.uk/news/new-marketing-strategy/>

## 5. Branding of stop smoking services

All service providers can use the Smokefree brand providing its use is in accordance with the branding guidelines.<sup>f</sup> The use of the NHS logo is no longer permitted unless providers are part of the NHS.

Services provided and commissioned by non-NHS organisations, such as local authorities, can still refer to themselves using the term “NHS stop smoking service” as long as they provide a line of text to explain why they are doing this, e.g. “name of organisation is working with the NHS to provide this stop smoking service”.

## 6. Methods of stopping smoking

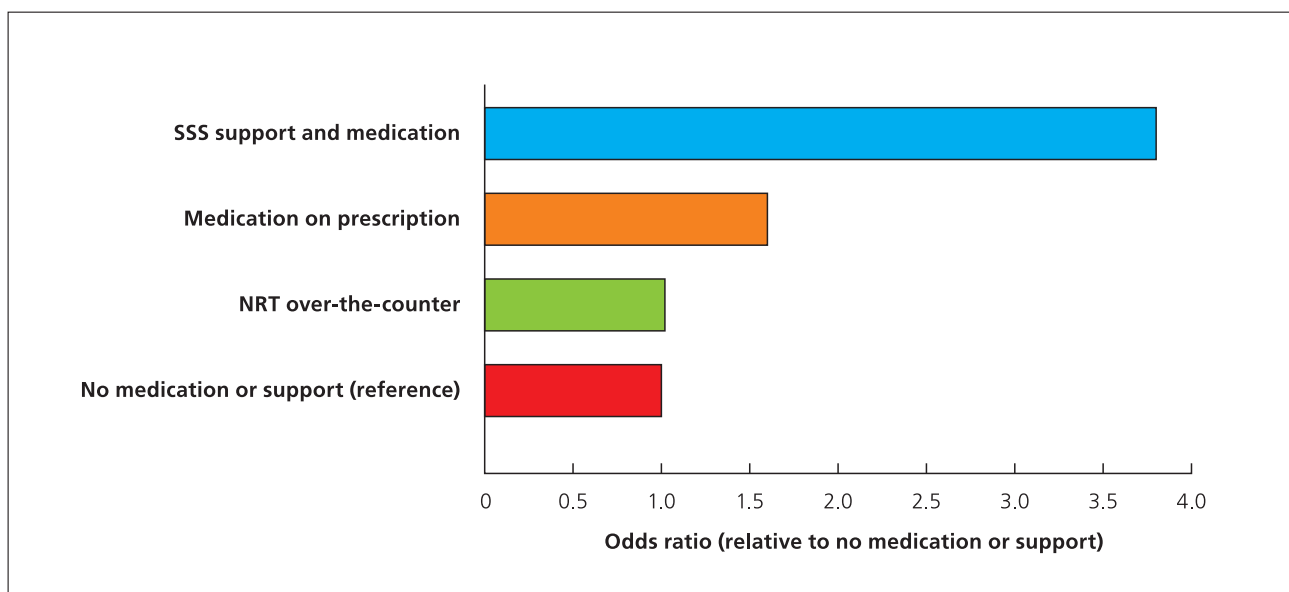
When attempting to stop smoking there are a number of methods that smokers commonly use, including

- Unassisted ('cold turkey')
- Using nicotine replacement therapy bought over the counter (OTC)
- Using a stop smoking medicine provided on prescription
- Using a stop smoking service (behavioural support plus access to stop smoking medicines)

Other methods sometimes cited by smokers, such as hypnotherapy, acupuncture and the Allen Carr Easy Way, do not have sufficiently strong evidence to support their use<sup>2</sup> and cannot be recommended as treatments provided by the NHS (see page 26).

Figure 2 uses STS data<sup>13</sup> and shows that OTC medication has no greater effect on smoking cessation rates than quitting unassisted. The most effective method remains a combination of stop smoking medicine and behavioural support of the type provided by stop smoking services (referred to as SSS support in Figure 2).

**Figure 2: Methods of stopping smoking and their success rates**



<sup>f</sup> [http://resources.smokefree.nhs.uk/wp-content/resources/files/pdf/SF\\_Guidelines\\_inter.pdf](http://resources.smokefree.nhs.uk/wp-content/resources/files/pdf/SF_Guidelines_inter.pdf)

## 7. Use of unlicensed nicotine containing products

There are a number of unlicensed nicotine containing products available on the market, such as nicotine vapourisers (e-cigarettes). Unlike those licensed products regulated by the MHRA (e.g. patches, gum, nasal and mouth sprays, sublingual tablets, lozenges, strips and the inhalator), there is limited evidence about their quality, safety or efficacy. Encouraging new evidence is emerging all the time, but currently there are no licensed nicotine vapourisers and thus these products cannot be prescribed or provided by stop smoking services, nor can they be recommended as a replacement for licensed medications.

Following a public consultation on unlicensed nicotine containing products, and commissioned research, the MHRA announced in 2013 that all such products would need to be licensed as medicines once relevant European legislation was introduced. This EU legislation was the Tobacco Products Directive (TPD). A new TPD was endorsed by the European Parliament in February 2014 and will be implemented from 2016. This requires all nicotine vapourisers containing over 20mg/ml of nicotine to be licensed as medicines but allows others to continue to be sold as consumer products but with some controls similar to those applied to tobacco products.

To date there remains limited evidence about the use of nicotine vapourisers for smoking cessation (evidence rating C<sup>9</sup>). However, expert opinion cited in the MHRA announcement and the NICE tobacco harm reduction guidance makes it clear that the use of nicotine vapourisers is likely to be considerably less hazardous than tobacco smoking. On this basis, services should, as part of the commissioning arrangement, still be able to provide behavioural support to clients who wish to use unlicensed, self-purchased products, whether this use is in combination with or instead of a licensed product.

Provided they adhere to the Russell Standard, stop smoking services can include in national data returns clients who are smoking tobacco, receiving behavioural support and who are using a nicotine vapouriser (or other unlicensed nicotine containing product) to help them stop.

Clients who have not smoked in the 48 hours prior to attending their first session, whether they are exclusively nicotine vapouriser users or not, are considered non-smokers and cannot be included in national data returns. However, they may be reported to commissioners locally as examples of recipients of additional services provided.

Services may also wish to provide support to people who do not smoke tobacco and want to stop their nicotine vapouriser use; however, this should not detract from the provision of services to people who wish to stop smoking tobacco. Assessing service capacity to deliver such a service is vital, as is consideration of the desired commissioning outcomes, including rules for remuneration.

Further information about nicotine vapourisers (e-cigarettes) can be found here:

**ASH briefing on e-cigarettes:** (see [www.ash.org.uk/files/documents/ASH\\_715.pdf](http://www.ash.org.uk/files/documents/ASH_715.pdf))

**NCSCT briefing on e-cigarettes:** (see [www.ncsct.co.uk/publication\\_ecigarette\\_briefing.php](http://www.ncsct.co.uk/publication_ecigarette_briefing.php)).

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g See page 24.

## 8. Stop smoking interventions

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


- Brief interventions
- Individual behavioural counselling
- Group behaviour therapy
- Licensed pharmacotherapies: NRT, bupropion (Zyban) and varenicline (Champix)
- Self-help materials
- Telephone counselling and helplines

There is also emerging evidence on new media interventions for smoking cessation (online, text messaging, computer assisted and smartphone app),<sup>35</sup> although these are not currently covered by NICE guidance.

The delivery section (Part 2) of this document provides greater detail regarding stop smoking interventions and specific smoking population groups (see page 42). Evidence ratings, also included in the delivery section, are summarised below in Tables 2 and 3 for ease of reference.

### Evidence ratings of recommendations

Every recommendation in the delivery section (Part 2) of this guidance has a rating to show the extent to which it is evidence based. This is based upon an adapted version of the Scottish Intercollegiate Guidelines Network (SIGN) rating system,<sup>36</sup> an internationally recognised scale used to rate research evidence. These ratings are as follows.

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

In order to grade the evidence in this guidance, reviews of published research were conducted. The process included identifying relevant systematic reviews and primary studies of smoking cessation interventions. Particular attention was paid to reviews conducted to inform NICE guidance and primary studies conducted in the UK due to their relevance for English stop smoking services.



**Table 2: Summary of interventions and their evidence rating**

Intervention	Evidence rating
Very brief advice	A
Behavioural support	A
<b>Intervention types</b>	
One-to-one support	A
Couple / family support	I
Closed-group support	A
Open (rolling) group support	B
Drop-in support	I
Telephone support	
Proactive	A
Reactive	B
Text-based	B
Online support	B
<b>Assessing nicotine dependency and smoking status</b>	
Quantitative approach to assessing nicotine dependency	A
Carbon monoxide testing	A
Cotinine testing	A
<b>Pharmacotherapy</b>	
Nicotine replacement therapy	A
Combination nicotine replacement therapy	A
Nicotine-Assisted Reduction to Stop (NARS) / preloading	B
Unlicensed nicotine containing products (nicotine vapourisers)	C
Bupropion (Zyban)	A
Varenicline (Champix)	A
<b>Smoking populations</b>	
Routine and manual smokers	B
Pregnant smokers	B
Nicotine replacement therapy	C
Teenage pregnancy	✓
Smoking and mental health problems	B
Secondary care	A
Prisoners	C
Substance misusers	C
Black and minority ethnic groups	B
Children and young people	
Stop smoking interventions	I
Prevention and tobacco control	B
Relapse prevention	I
Repeat service users	✓

Other interventions and products that are either not recommended or are currently lacking sufficient evidence to be included in the delivery section are summarised below.

**Table 3: Other interventions**

Intervention / product
<b>Some evidence of effectiveness but not currently recommended</b>
Rapid smoking Cytisine Incentives
<b>Insufficient evidence: not currently recommended</b>
Allen Carr Nicobrevin NicoBloc St John's Wort Glucose Lobeline
<b>Evidence of no effectiveness: not recommended</b>
Hypnosis Acupuncture Acupressure Laser therapy Electrostimulation Anxiolytics

## Stop smoking service configuration

Historically, each Primary Care Trust funded a core stop smoking service to provide a wide range of functions in addition to the delivery of evidence-based cessation interventions, e.g. training, mentoring and communications campaigns. Over recent years, the commissioner and provider split and the emergence in some areas of payments by results (PbR) has resulted in adaptations to this model.

A mapping exercise of stop smoking service commissioners undertaken in 2014 showed that the majority of responding areas either commissioned one provider via a block contract (30%), which could itself sub-contract other providers, or directly commissioned multiple providers (31%) that were each required to achieve a proportion of the overall target. There is currently no evidence to suggest the single most effective commissioning model, but the basis upon which services are commissioned should be informed by the evidence ratings (page 25), intervention principles (page 29) and treatment programme content (page 31) contained in this document.

In 2011, over 126,000 service treatment episodes in England were analysed to identify the factors that influence service effectiveness.<sup>37</sup> A substantial variation in success rates across intervention characteristics was found after adjusting for smoker characteristics. The study concluded that the following factors increased the likelihood of quitting:

- Behavioural support provided by a practitioner whose main job is stop smoking provision
- Behavioural support delivered in a group setting
- Use of varenicline or combination NRT

Although offering greater reach and accessibility, interventions delivered by community stop smoking practitioners whose main job is not stop smoking provision (e.g. practice nurses, community pharmacy staff, etc.) are in general less effective than interventions delivered by specialist stop smoking practitioners for whom it is the sole or main part of their job. To increase and maintain the effectiveness of interventions, it is important that all stop smoking practitioners are NCSCT certified, receive face-to-face training in line with the national training standard,<sup>h</sup> receive support and supervision and participate in update training at least once a year.

It is also important to consider the wider functions required to deliver a coordinated and cohesive approach to the delivery of local, high-quality, evidence-based stop smoking interventions and to identify how these will be provided, including:

- Development and maintenance of local referral networks
- Training of providers, including regular supervision, update training and continuing professional development
- Coordination and management of local marketing campaigns and communications as well as national events such as No Smoking Day, World No Tobacco Day and Stoptober
- Coordination and management of quarterly data collections, including for higher risk groups, service access, exception reporting and auditing
- Management of local referrals and allocation to providers
- Membership and representation within local tobacco control alliances

Whichever commissioning model is used locally, service provider contracts should include a detailed service specification that clearly lays out the criteria for delivery and reporting.

A checklist for commissioners is provided in Annex A.

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<sup>h</sup> The national training standard can be found here:  
[www.ncsct.co.uk/publication\\_ncsct-training-standard-learning-outcomes-for-training-stop-smoking-practitioners.php](http://www.ncsct.co.uk/publication_ncsct-training-standard-learning-outcomes-for-training-stop-smoking-practitioners.php)

## Balancing reach and efficacy of interventions

There is evidence to show an inverse relationship between numbers treated and success rate: a drive for high numbers tends to result in lower success rates. The balance of commissioning interventions that addresses the needs of groups that are hard to engage, whilst remaining relevant and accessible to the mainstream smoking population, requires particular attention. An overview of the different intervention types is provided on page 47.

Interventions such as closed-groups are highly effective and should form part of the range of services provided. Support provided through primary care, pharmacies and dental settings can provide a greater level of flexibility and be more attractive to service users, but the trade-off for greater footfall is often lower quit rates. Providing a range of support options, in line with evidence-based intervention principles, will ensure that clients have the opportunity to choose a service that best suits their needs.

The dynamic between increased accessibility and increased likelihood of cessation is one that should be explored, because it may result in providers being allowed to offer an increasing level of intervention to clients who repeatedly present to services. As with other clinical services, there is no value to be added by repeatedly recommending an intervention that returns a suboptimal outcome for an individual. Rather than recycling clients through similar 'failure modes', service providers should be encouraged to identify these individuals and offer them increasing levels of support. Note that this does not mean that first-time service users should be offered anything less than the standard intervention for all smokers.

## Targeting priority groups

Understanding the local demographics within each area will help identify priority groups. Nationally, smokers with a mental disorder (mental illness, alcohol problems and substance misuse), pregnant smokers and those in routine and manual occupations are considered key priority groups.

Prisoners, the homeless and other groups such as LGBT communities in which smoking prevalence is especially high also require proportionate targeting.

Matching services to local need requires commissions that are designed to engage and support smokers from diverse groups, either specifically or as part of the wider service offer. Where there is a specific requirement for intervention, these groups must be clearly referenced in service specifications and included within service outcomes and key performance indicators. Smokers from high prevalence groups are likely to require longer and possibly more intensive support, and this should also be considered in relation to payment schedules and incentivising service activity.

Data submitted by service providers can support commissioners in monitoring access and success rates for priority groups. Commissions should require a minimum throughput of smokers setting a quit date from these groups that is at least proportionate to their representation within the local smoking population. Where there are particular issues of inequity, commissions may require an increased level of engagement to ensure that smoking rates are driven down at a rate greater than that expected in the general population.

Commissioners who identify communities within their localities with high rates of smokeless tobacco use (see page 77) may also consider this priority group and look to commission services to help them to stop. Recent NICE guidance on smokeless tobacco cessation provides further information regarding supporting South Asian community members to stop using smokeless tobacco.<sup>38</sup>

## 9. Delivering interventions

All stop smoking service interventions should adhere to the quality principles based on current NICE guidance and be responsive to changes in the evidence base and current thinking on clinical best practice. A complete list of behavioural support competences has been developed by the National Centre for Smoking Cessation and Training (NCSCT) and is available as learning outcomes listed in the NCSCT Training Standard (see [www.ncsct.co.uk/publication\\_ncsct-training-standard-learning-outcomes-for-training-stop-smoking-practitioners.php](http://www.ncsct.co.uk/publication_ncsct-training-standard-learning-outcomes-for-training-stop-smoking-practitioners.php)).

### Intervention principles

- Interventions should be based on the current evidence base and where applicable follow NICE guidance. See Appendix C
- Prior to treatment, clients should be informed of all available (evidence-based) treatment options
- Stop smoking service provision should be guided by a treatment manual clearly indicating the elements of a behavioural support programme and when and how they should be applied. This manual should follow recommended practice from evidence-based national guidelines<sup>i</sup>
- All staff involved in delivery should have been trained to the NCSCT Training Standard and should obtain full NCSCT certification. In addition to the completion of the national online training, it is also recommended that practitioners receive face-to-face training and participate in a period of shadowing and observation before providing support unsupervised. Ongoing supervision and mentoring is also important to ensure providers retain core skills and knowledge and are made aware of developments in the field

Practitioners providing support to pregnant women and/or those with a mental health problem are encouraged to take the online NCSCT specialty modules, which are available to all those who achieve full NCSCT certification

- All interventions should be multi-sessional, offering weekly support for at least the first four weeks following the quit date
- One-to-one interventions should have a total potential client contact time of at least 1 hour 50 minutes<sup>j</sup> (from pre-quit preparation to four weeks after quitting). This will ensure effective monitoring, client adherence to the treatment programme and ongoing access to medication

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i An example Standard Treatment Programme is available at:  
[www.ncsct.co.uk/publication\\_ncsct-training-standard-learning-outcomes-for-training-stop-smoking-practitioners.php](http://www.ncsct.co.uk/publication_ncsct-training-standard-learning-outcomes-for-training-stop-smoking-practitioners.php)

j This represents an increase of 20 minutes from the minimum contact time stipulated in previous editions of this guidance. This change has been made to better reflect a realistic amount of time required to deliver the evidence-based competences that constitute effective stop smoking support. It should be noted that even with such an increase this remains a minimum contact time and does not take into account additional time that may be required to effectively support individual clients. It also does not take account of related administrative tasks such as the completion of paperwork and session notes.

### One-to-one behavioural support sessions (minimum support for the first six weeks)

Session	Minimum time allocated (minutes)
<b>Session 1: Pre-quit</b>	30
<b>Session 2: Quit date</b>	20
<b>Session 3: 1 week post-quit</b>	15
<b>Session 4: 2 weeks post-quit</b>	15
<b>Session 5: 3 weeks post-quit</b>	15
<b>Session 6: 4 weeks post-quit*</b>	15
<b>Total</b>	1 hour 50 minutes

\* Further sessions may be provided as per local protocol. Clients will need to be able to access the full course of their chosen stop smoking medicine(s) (see page 32).

- Group-based intervention sessions should be at least an hour in length and offer a minimum total of six hours' contact over a six-week treatment period. The behavioural support content of group treatment should mirror that of an individual treatment programme
- Smoking status at four weeks from the quit date should be CO validated in a minimum of 85% of cases
- Interventions should be efficiently managed with sufficient administrative support for general organisation, client contact processes and data handling. Clients should be contacted as soon as referral details are received and in no case later than two working days from receipt of referral, with an appointment offered within one week. Every service should have a protocol for the effective management and handling of calls and require all call handlers to be trained in effective customer service techniques
- It is recommended that new delivery models are initially piloted and fully evaluated before being adopted as a significant part of the local delivery. This may, for example, include harm reduction interventions (see Annex F, page 96, for an evaluation pro forma)
- Service providers should be independently audited at regular intervals to ensure that the intervention being provided is of the expected quality and duration, as set out in this document (also see Exception reporting, page 84)

## Treatment programme content

The treatment programme should, as a minimum, include:

- Building rapport and boosting motivation throughout
- Assessing and confirming current readiness and ability to quit
- Informing clients about the treatment programme
- Assessing current smoking behaviour
- Assessing past history of quit attempts
- Explaining how tobacco dependence develops and assessing level of nicotine dependence (using diagnostic criteria such as the Heaviness of Smoking Index (HSI) or the Fagerström Test for Cigarette Dependence (FTCD))
- Measuring carbon monoxide (CO)
- Explaining the importance of abrupt cessation and the 'not-a-puff' rule
- Discussing withdrawal symptoms and cravings/urges to smoke and how to deal with them
- Discussing stop smoking medications; confirming choice, correct usage and sufficient supply
- Discussing the client's smoking contacts and how the client can get support to quit
- Setting a quit date
- Discussing any potential high-risk situations in the coming week
- Advising on changing routine
- Prompting commitment from clients (confirm the importance of the 'not-a-puff' rule)
- Discussing future preparations and plans
- Relapse prevention
- Providing a summary to the client

A full overview of the evidence-based competences and components per treatment session is provided in the NCSCT Standard Treatment Programme.<sup>k</sup>

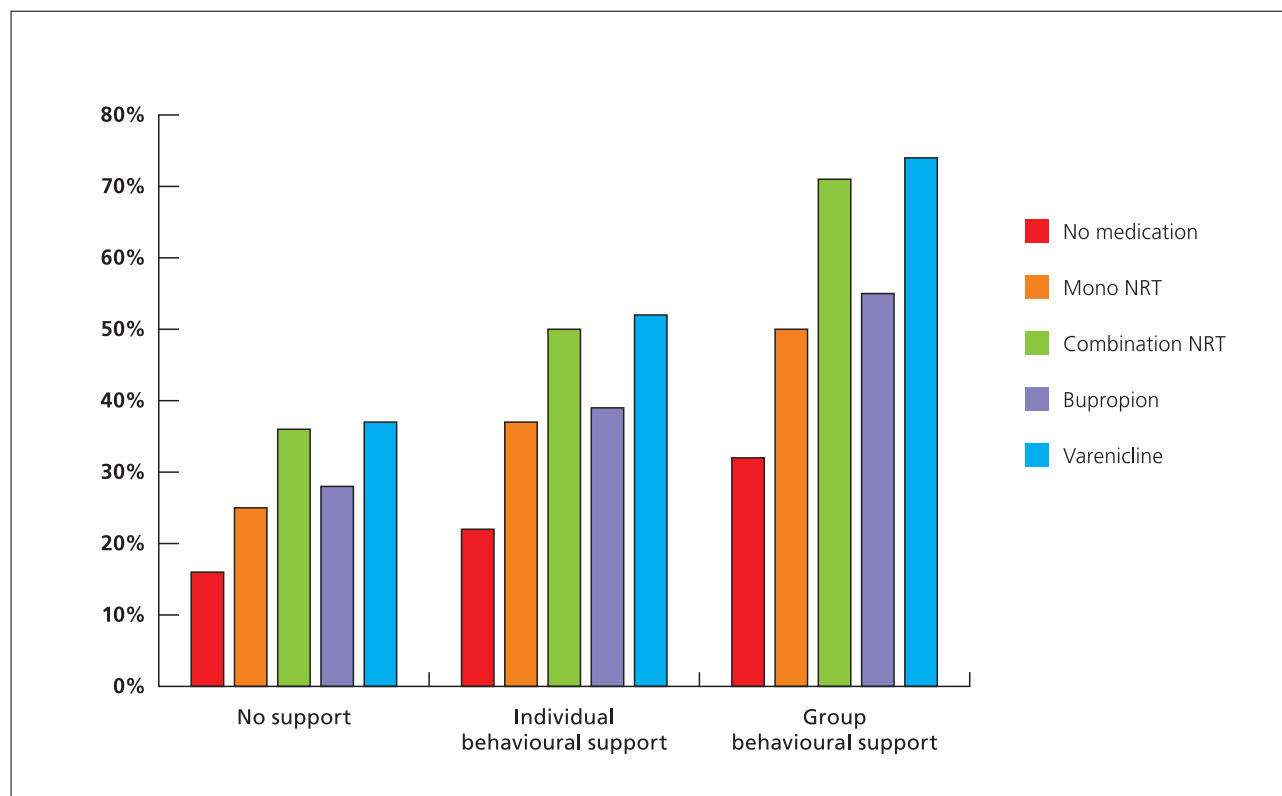
## Efficacy and intervention mix

Whilst every smoker will have individual preferences that will influence their choice of intervention, it is important that options are 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).

Figure 3 and Table 4 show the relative impact of a variety of evidence-based stop smoking interventions and pharmacotherapies on four-week quit rates.

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<sup>k</sup> [www.ncsct.co.uk/usr/pub/standard\\_treatment\\_programme.pdf](http://www.ncsct.co.uk/usr/pub/standard_treatment_programme.pdf)

**Figure 3: Effectiveness of pharmacotherapy and support options****Table 4: Effectiveness of pharmacotherapy and support options**

Four-week quit rates	No medication	Mono NRT	Combination NRT	Bupropion	Varenicline
No support	16%	25%	36%	28%	37%
Individual behavioural support	22%	37%	50%	39%	52%
Closed group behavioural support	32%	50%	71%	55%	74%

Source: Cochrane Database of Systematic Reviews extrapolated by West and Aveyard<sup>39</sup>

### Licensed pharmacotherapy

As all smokers should be given the optimum chance of success in any given quit attempt, licensed pharmacotherapy, currently nicotine replacement therapy (NRT), varenicline (Champix) and bupropion (Zyban) should all be made available in combination with intensive behavioural support. Varenicline or combination NRT offer smokers the best chances of quitting and, unless clinically contraindicated, should be available as first-line treatments to all clients.



## Pharmacotherapy budgets

Upper tier local authorities have a statutory duty to take appropriate steps to improve the health of their populations. When local authorities assumed responsibility for commissioning public health services in 2013, this included the supply of any associated medicines or devices.

The public health allocations, provided by the Department of Health to each local authority, were intended to cover the full costs of supplying medicines, including those provided on prescription. This means that where a smoker is receiving support from a stop smoking service to quit, local authority budgets should be used to fund the standard provision of stop smoking medications, e.g. up to 12 weeks for NRT and varenicline and up to nine weeks for bupropion.

Sometimes there is a clinical need for medication to be provided for longer, and the licensing of these medications (with the exception of bupropion) allows for this. Funding for longer-term provision of medications should be negotiated between the local authority and the CCG.

However, in instances where a GP (or other prescriber) prescribes a stop smoking medicine to address a particular patient's clinical needs outside the local authority commissioned pathway, the costs of the prescription should be met from the CCG budget, as with any other clinical intervention.

The Public Health Policy & Strategy Unit at the Department of Health has developed a fact sheet addressing this: (see [www.nhsbsa.nhs.uk/PrescriptionServices/Documents/PrescriptionServices/NHS\\_Reforms\\_factsheet\\_5\\_v2.0.pdf](http://www.nhsbsa.nhs.uk/PrescriptionServices/Documents/PrescriptionServices/NHS_Reforms_factsheet_5_v2.0.pdf)).

### Best practice points

- All licensed stop smoking pharmacotherapies should be available as equal first-line options
- All pharmacotherapies should remain available for at least the duration recommended by the product specification
- Accessing approved stop smoking medicines should be an easy process
- Those involved in the provision of stop smoking medications should complete the NCSCT online medications module (once available)
- Pharmacotherapies should be available for more than one treatment episode<sup>1</sup>
- Where a client relapses during a quit attempt (and does not wish to begin a new treatment episode), no further pharmacotherapy should be provided until such time as the client is motivated to make another quit attempt

As with all medicines, any adverse reactions should be reported using the yellow card scheme, which can be found at <http://yellowcard.mhra.gov.uk/>.

To make it easier for clients to access stop smoking medications, many areas have developed voucher schemes or implemented Patient Group Directives (PGDs).

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<sup>1</sup> For example, a client using Champix who relapses during a quit attempt should, providing they are committed to attempt to stop again, be able to begin a new course of Champix if this is assessed to be the most appropriate medicine for that client.

### **The supply of NRT via voucher schemes**

NRT products are classified as General Sales List (GSL). This means that, depending on local policy, a patient group direction (PGD) is not necessary and they can therefore be supplied directly from pharmacies without a prescription.

The aim of the voucher scheme is to enable clients to access NRT when attending a stop smoking service without the need to see the GP. A voucher process doesn't usually require the involvement of a GP and other clinical leads, which would be required in the writing and development of PGDs. Voucher schemes are commonly seen as a customary option for GSL products such as NRT. These schemes do not normally have a defined inclusion or exclusion criteria (unlike a PGD) that the healthcare professional has to abide by, although such guidance is recommended.

A voucher is normally issued by a stop smoking practitioner after assessing the suitability of a particular medication with the client. The medication should be issued by a pharmacist and ideally be labelled with clear instructions, especially if they are not clear on the packaging. The pharmacist should always check the patient medication records for any potential contraindications and cautions as, ultimately, the responsibility for providing NRT through this type of scheme lies with the pharmacist.

Standard Operating Procedures (SOPs) and clinical governance processes should be set up and adhered to at all times to assure patient safety. An example NRT protocol is available here: [www.ncsct.co.uk/publication\\_pgd\\_and\\_voucher.php](http://www.ncsct.co.uk/publication_pgd_and_voucher.php).

### **Direct supply of NRT**

As an alternative to voucher schemes, some service providers have opted to directly supply NRT to their clients, purchasing and managing their own NRT stocks and developing service protocols and/or PGDs to guide the provision of products.

### **Patient group direction (PGD)**

PGDs allow specified healthcare professionals to supply and/or administer a medicine directly to a patient with an identified clinical condition without the need for a prescription or an instruction from a prescriber. They can, for example, offer an alternative method of providing access to varenicline or bupropion rather than via GP prescription only.

The individual healthcare professional assigned to the PGD is responsible for assessing that the patient fits the criteria set out in the PGD. The supply and/or administration of medicines under a PGD cannot be delegated (e.g. to a pharmacy technician or student nurse).

PGDs may not always be the best way to supply GSL medicines (such as nicotine replacement therapies) because the PGD has to be followed precisely and there is little room for professional discretion. However, PGDs are considered to be a method that assures patient safety more rigorously than other supply methods.

### Case study: PGD for varenicline (Champix)

In 2013, Worcestershire County Council decided to implement a PGD for Champix. It was hoped that by removing the steps currently required in order for clients to access Champix (i.e. the need to take a recommendation letter to the GP, return to collect a prescription and then go to the pharmacy to receive the prescription), this effective medication would be more available to more of their clients. There had been a pharmacy voucher scheme in place for NRT for 10 years that had worked well and it was thought that a Champix PGD would complement this option.

A project management team was established to oversee the development and implementation of the PGD, which included the local authority head of public health, the chief officer for the local pharmaceutical committee, a GP representative from one of the CCGs, a senior pharmaceutical practitioner from the commissioning support unit, the local authority strategy and policy development officer and the commissioning manager. It took approximately five months from the first project group meeting to the 'soft' launch of the PGD in December 2013.

#### Key learning points from the project were:

- local pharmacy committee (LPC) and commissioning support unit involvement is crucial and they should be part of the project team
- Managing the distribution and collation of contracts, as well as establishing processes for payment, can be time intensive initially and dedicated administrative resources may be required
- VAT on Champix is charged at 5%
- Include a client-held record from the outset (in Worcestershire this was introduced after the launch at the request of the pharmacists and would have been useful from the beginning)
- Packs must be appropriately labelled and this requirement should be included in the service specification
- There is likely to be a minimum requirement in terms of assuring that pharmacists signed up to the PGD have attended the necessary training, and this needs to be identified as part of the project planning
- Training events can easily become more focused on operational matters rather than the content of the PGD and therefore it is useful to make the objectives of the training clear from the beginning and to make sure that there is an alternative mechanism in place to handle more operational matters
- Following implementation the PGD should continue to be reviewed

To date, 94 clients have used the Champix PGD and it appears to be very successful with no problems reported. Some GP practices (that are commissioned stop smoking services) prefer to refer for Champix under PGD rather than prescribe to reduce GP appointment time.

An example PGD and service specification for the provision of Champix via community pharmacies can be accessed here: [www.ncsct.co.uk/publication\\_pgd\\_and\\_voucher.php](http://www.ncsct.co.uk/publication_pgd_and_voucher.php).

## 10. Measuring success

The national outcome measure of stop smoking services remains success rates at the four-week post-quit date. In addition to this, many local areas capture a wider range of outcomes, some examples of which are listed below. Commissioners who took part in a mapping exercise this year reported that, whilst smoking status at four weeks was the most common local measure, other outcomes such as the 12-week quit status and separate reporting of outcomes for priority population groups were in place.

Outcomes reported by local areas:

- Number of quit dates set
- Number of 4, 12 and 52 week quitters
- CO-validation rate
- Quit rate
- Customer satisfaction
  - Number completing questionnaires
  - Percentage of clients satisfied with the service
- Number referred to the service
  - In total
  - From identified geographical areas
  - From identified specific local smoking populations
  - By referral source
- Number of nicotine vapouriser users supported by the service
- Promotional activity, e.g. number of press release and/or press advertisements
- Number of staff trained

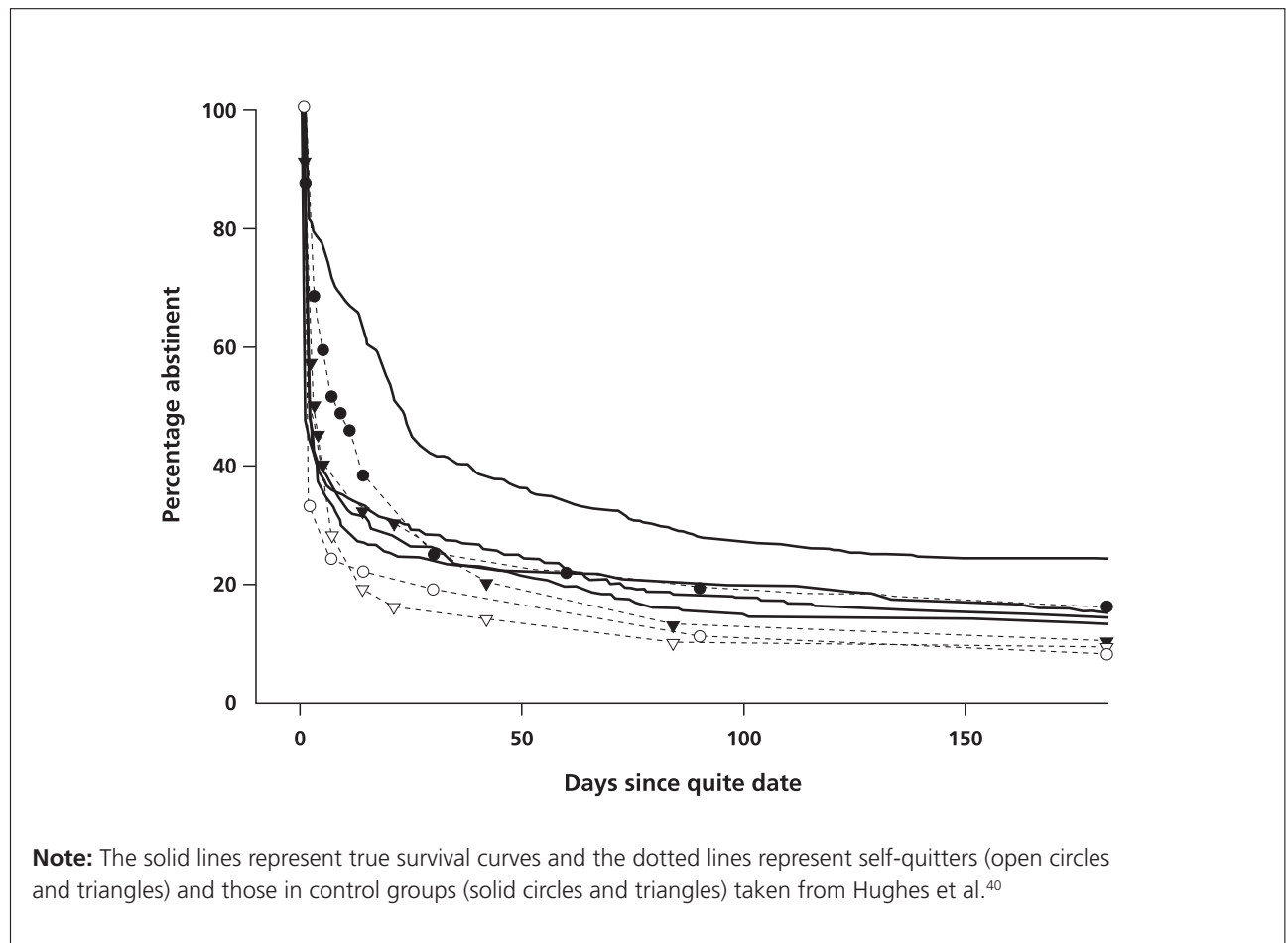
Over one-third (37%, n=26) of commissioners reported using a specific formula to calculate cost per quitter, although the methods used were varied and inconsistent. The national average cost per quitter in 2012/13,<sup>m</sup> excluding pharmacotherapy costs, had increased to £235 (ranging from £181–£351).<sup>9</sup> However, it should be noted that budgets have decreased at a lesser rate (5%) than quits (11%), which could explain such an increase. The national figure should be treated with caution because, whilst guidance has been provided nationally, areas have not always been sure about what should and should not be included in the cost data submitted to the HSCIC. From 1st April 2014, the quarterly national data collection was changed to allow for collection of cost data relating to pharmacotherapy as well as to core service delivery.

### Rationale for measuring four-week quit status

The use of four-week quit rates as an outcome measure for services has often been questioned, largely on the basis that they do not capture long-term quitters. However, CO-validated smoking status outcomes at four weeks have very stable relapse rates that are predictable and well documented in the research literature (see Figure 4) and allow longer-term success rates to be calculated with a high degree of confidence.

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<sup>m</sup> Due to incomplete or missing data from seven local authorities, cost per quitter for 2013/14 was not reported at a national level in the latest 'Statistics on NHS Stop Smoking Services in England'.<sup>9</sup>

**Figure 4: Relapse curve**

### Longer-term follow-up

Where resources allow, and in addition to the monitoring of four-week quit outcomes, longer-term follow-up data, e.g. at 12 and 52 weeks, may provide a further check of efficacy, especially when considering specific populations or when aiming to add confidence to the outcomes of pilot projects.

There is no published evidence to suggest that measuring longer-term outcomes instead of, or in addition to, those at four weeks adds value.<sup>n</sup> However, setting targets around continued monitoring can encourage providers to support their clients for longer, and this may be desirable in terms of ensuring that clients gain maximum benefit from their medication use. Longer follow-up periods can also allow services to re-engage with smokers who have lapsed or relapsed.

In general, however, following up service users over longer periods (such as 52 weeks) can become very resource-intensive, and the success of this process is often subject to whether contact details change.

National data collection is based upon the four-week point, and this remains the recommended outcome measure for stop smoking services, irrespective of additional measures introduced locally.

n A briefing comparing the benefits of 4-week and 12-week follow-up of clients has been published by the NCSCT: [www.ncsct.co.uk/publication\\_Four\\_week\\_quit\\_rate\\_briefing.php](http://www.ncsct.co.uk/publication_Four_week_quit_rate_briefing.php)

### Measuring impact

Smokers attempting to stop using medication only and with no additional behavioural support have a success rate at four weeks of approximately 25% (CO validated) and 35% (self-reported).<sup>o</sup> Therefore, to demonstrate that they are adding value to quit attempts, and having an impact upon local smoking rates, services must achieve success rates in excess of these.

An impact formula has been developed that can be used to estimate the extra number of short-term ex-smokers that a service has generated, in addition to those who would have been expected to quit anyway if they had only received medication on prescription and no behavioural support.

The time period over which the impact has been achieved is dependent upon the time period that the data (used to calculate the impact) is from.

---

o The best estimate of the 30-day abstinence figure in untreated smokers is 18–28%. NRT with minimal behavioural support has been found to increase success rates by about 50%, giving a range of 27%–42%. Taking the lower estimate of 27% and rounding down to 25% gives an approximate minimal level of success that would be expected for smokers receiving medication and minimal behavioural support. Given the evidence that self-reported success overestimates true success by about 10%, the self-report baseline figure needs to be some 10% higher. These figures do not take account of the fact that the 4-week success rates of the services allow for smoking during the first two weeks. It is not known what effect this might have; however, if anything, it would raise the baseline figure even higher. Further, specific research is required to inform baselines for specific smoking population groups.

## Calculating impact

$$I = N \times (Q - 25) \div 100$$

where

**I** = the number of short-term ex-smokers generated by the service over and above those who would have stopped otherwise (the calculated impact)

**N** = the numbers setting a quit date per 100,000 smokers (derivable from number of adults multiplied by the estimated proportion smoking)\*

**Q** = percentage of CO-verified 4-week quitters

**25** = the percentage of smokers who would be expected to stop if they had just used medication obtained on prescription.

\* **Note:** the published national stop smoking service data includes analysis per 100,000 of the adult population, but this is based upon general population statistics and is not restricted to the smoking population. Therefore this data cannot be used in this calculation.

### Worked example

Area A has the following estimated statistics:

<b>Total population (aged 16+)</b>	188,886
<b>Local smoking prevalence</b>	23.6%
<b>Local population of smokers</b>	44,577 (188,886 x 0.236)
<b>Number of quit dates set through the stop smoking service</b>	4,747
<b>Number of quit dates set per 100,000 smokers</b>	10,649 (4,747 ÷ 0.44577)
<b>Number of four-week quitters (CO verified)</b>	2,042
<b>CO-verified quit rate</b>	43% (2,042 ÷ 4,747)

The stop smoking service in area A has achieved the following impact score:

$$\begin{aligned}
 \text{Impact} &= 10,649 \times (43 - 25) \div 100 \\
 &= 10,649 \times 18 \div 100 \\
 &= 191,682 \div 100 \\
 &= 1,916.8 \text{ (1,917) short-term quitters directly generated by the service.}
 \end{aligned}$$

## Establishing smoking status

Of the biochemical methods used for establishing smoking status in individuals attempting to quit (see page 51), the most cost-effective and least invasive of these is the measurement of expired air, CO. Since self-reported smoking status can be unreliable,<sup>41,42</sup> CO-validation rates are important markers of data quality. CO monitoring is also an important motivational tool and evidence-based behaviour change technique.

The recommendation that services aim for a minimum CO-validation rate of 85% of all reported four-week quits refers to actual verification rates and not just that an attempt to verify was made in 85% of cases.

This is important in order to assure the reliability of the data that is used to inform local and national planning. Although CO-validation rates have increased since 2007–08, the latest data indicates a national average CO-validation rate of 70% and wide variation in rates across areas.<sup>9</sup> There still remains, therefore, some way to go before achieving the recommended level.

The rural profile of an area or the provision of non-face to face interventions (e.g. telephone support) is often cited as a barrier to CO verification. It is therefore important that such factors are taken into consideration when designing and commissioning such services. For example, in some areas where telephone support is provided as part of the service, local pharmacies are contracted to undertake CO readings as part of the NRT voucher scheme. Requiring a client to present at a pharmacy to receive the fourth week's dose of their medication can ensure that a CO reading is taken and can provide an extra opportunity for ensuring medication is being used correctly. These readings are then shared with the local service providers so that they can verify treatment outcomes.

Commissioners play a key role in ensuring that as part of their contracts providers have the capacity and capability to comply with CO-monitoring requirements. In turn, providers have responsibility for implementing and providing evidence of effective quality systems for CO monitoring. Responsibility for providing and maintaining CO monitors needs to be clear in contractual agreements.

## 11. Return on investment

The National Institute for Health and Care Excellence (NICE) was asked by the Department of Health to develop a prototype model for local authority commissioners showing the potential return on investment (ROI) for health improvement interventions. This initially focused on tobacco control and has since been extended to interventions for alcohol misuse and physical inactivity.

The development of the tools was informed by a NICE cost impact project that was set up to explore the feasibility and usefulness of producing a range of cost-effectiveness, cost impact and ROI data and tools to support local decision-making. The project showed that a wide range of different metrics and tools are needed to support effective decision-making at a local level.

### Tobacco ROI tool

The tobacco tool is an Excel-based Markov model that provides return on investment information for different user defined 'packages' of tobacco control interventions within a fixed geographical area (e.g. region or local authority). The effectiveness of the intervention is measured as the increase in the percentage of people who stop smoking. The following metrics are presented in the tool: NHS and societal net present value (NPV) savings, incremental cost-effectiveness ratio (ICER), and benefit–cost (B–C) ratios).



## Case study

To illustrate the costs and savings that can be achieved by tackling tobacco use, the tool was run for a local authority (LA) with an adult population (18+ years) of 274,324, of whom roughly 47,974 (17.5%) are current smokers. A selection of the results is presented below.

### How much smoking costs the LA

The total annual cost of smoking in the LA is £18,270,635, which can be broken down as:

- Costs to businesses (productivity losses): £8,639,576
- NHS costs: £9,013,636
- Costs of second-hand smoke exposure: £613,947 (adults: £496,363; children: £117,584)

### Cost of current provision of local stop smoking services (LSSS)

The package of interventions currently offered by the LSSS in the LA is estimated to cost £715,393 in the first year.

### Return portfolio

In the short term (first two years) the package of interventions leads to gross savings (not including the cost of implementation) that can be broken down as:

- **Cost savings to businesses** (public, private, voluntary) **£192,407**  
(1,565 fewer days lost due to smoking)
- **Cost savings to the NHS** **£200,900**  
(1,198 fewer GP consultations, 206 fewer outpatient visits)
- **Cost savings to NHS** **£5,452**  
(168 fewer treatment cases of conditions resulting from exposure to second-hand smoke)

### Economic metrics

	2 years	5 years	10 years	Lifetime
Estimated net present value (NPV) savings per smoker (including the value of health gains) associated with the current level compared to no service provision	-£4	£11	£35	£130
The benefit–cost (B–C) ratio per £1 invested (including the value of health gains)	0.8	no data	no data	9.7
Estimated incremental costs to the NHS per quality adjusted life year gained (cost/QALY gained)	£30,021	£7,371	£344	no data

Over a lifetime the local stop smoking services are cost-saving, i.e. compared with the baseline, they provide more benefits and cost less. Generally, NICE considers that interventions costing the NHS less than £20,000 per QALY gained are cost-effective.

**Conclusion:** In this example, within a period of 5 years, and taking into account the value of the health gains, the economic metrics indicate that the package of interventions currently provided by the LSSS is highly cost-effective and represents very good value for money.

# PART 2: DELIVERING SERVICES


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This section provides an overview of the latest evidence supporting and informing the optimal delivery of stop smoking interventions. It also offers practical recommendations for stop smoking service providers in order to maximise their effectiveness.

### Evidence rating of recommendations

All of the recommendation in this section have a rating to show the extent to which they are evidence based. The evidence ratings are as follows and are based upon an adapted version of the Scottish Intercollegiate Guidelines Network (SIGN) rating system:<sup>36</sup>

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

In order to grade the evidence, reviews of published research were conducted. The process included identifying relevant systematic reviews and primary studies of smoking cessation interventions. Particular attention was paid to reviews conducted to inform NICE guidance and primary studies conducted in the UK due to their relevance for English stop smoking services.

## 1. Very brief advice

**Evidence rating:** **A**

Many health and social care professionals (HSCPs) have regular contact with people who smoke and who have, or are at risk of developing, smoking-related health conditions. Stop smoking interventions delivered by HSCPs that advise on the best way of quitting and offer referral to stop smoking services are clinically effective and cost-effective, and are directly in line with the Making Every Contact Count agenda.<sup>p</sup> Despite the effectiveness of stop smoking services, rates of take-up remain low.

Traditionally, brief interventions have been recommended to trigger quit attempts. However, it is not enough to only provide advice to stop; in order to be effective, brief interventions also need to include an offer of help. Smokers, who are offered help by their GP rather than only advice to stop, are twice as likely to make a quit attempt.<sup>43</sup>

The importance of recommending both support and treatment is further highlighted by a study which showed that compared with no advice or advice only from GPs to smokers, the odds of quitting are 68% higher if stop smoking medication is offered and 217% higher with the offer of support.<sup>44</sup>

Very brief advice (VBA) based upon Ask, Advise, Act offers a quick and effective approach that can be used by all HSCPs and any other professions with direct contact with smokers.

**Figure 5: Very brief advice**



### Example script of delivering an opt-out referral intervention to an identified smoker:

*"The best way of quitting is with a combination of support and medication. It is our policy to offer everyone who smokes a referral to our local stop smoking service where this is freely available. Are you happy for me to do that for you now?"*

### Maximising referrals

- Formal referral systems will provide a process for referrers to follow and can support analysis of referral information
- People are more likely to refer if the referral process and any associated paperwork / electronic programmes are simple and easy to use
- Treatment outcomes should be routinely fed back to referrers

In 2012, the NCSCT launched the Very brief advice on smoking online module (see <http://elearning.ncsct.co.uk/vba-launch>), which has been accessed by over 95,000 people.

To try and engage as many GPs as possible, the module was also made available to medics on the BMJ Learning website. To evaluate the module, 1,329 users of the BMJ website course were sent email invitations to take part in a survey (20.6% response rate).

In the year before completing the module, the average proportion of consultations in which survey respondents offered smokers help with smoking cessation was 36.8%; after completing the module the average reported intervention rate was 60.4%.

***“This is a really useful module. Has all the information you need and the use of video, slides and MCQ is engaging. The most advanced and engaging module I have completed on BMJ Learning.”*** Medic accessing the module

***“It’s inspiring, and helps to remind me of the point of asking about smoking.”***  
GP, Leicester

## 2. Stop smoking interventions

Evidence has shown that a combination of behavioural support from a trained stop smoking practitioner and licensed pharmacotherapy (see page 55) can significantly increase a smoker’s chances of stopping.<sup>45</sup>

All interventions share common properties (such as the provision of behavioural support, a structured approach and the offer of licensed pharmacotherapy) and they all involve multiple sessions. Stop smoking interventions can be delivered in a number of ways, and it is important that a range of support options is available to allow people to choose the type of intervention that is right for them.

More dependent smokers will require greater levels of behavioural support and a higher dose of or extended medication. They may also need to make multiple quit attempts and, as with other clinical services, there is no value to be added by repeatedly recommending an intervention that has proved unsuccessful in the past. Rather than ‘recycling’ clients through standard stop smoking programmes, service providers should be encouraged to identify these individuals and offer them enhanced levels of support.

The strongest and most consistent evidence for the efficacy and effectiveness of stop smoking interventions is for those that involve an ‘abrupt’ quit attempt (identifying a quit date and aiming to maintain complete abstinence after that date by adopting the ‘not-a-puff’ rule). The interventions in this section relate to that approach to smoking cessation, unless explicitly stated in the text.

A commentary on harm reduction is provided in Annex I.

## Behavioural support

### Evidence rating: **A**

Behavioural support involves delivering evidence-based behaviour change techniques, most commonly provided face to face (individually or in groups). It increases quitting success rates by:

- Helping clients to avoid, escape from or cope with urges to smoke and to manage withdrawal symptoms
- Maximising motivation to remain abstinent and achieve the goal of permanent cessation
- Boosting self-confidence
- Maximising self-control
- Optimising the use of pharmacotherapy

### Encouraging honest self-reports

When confirming four-week quit status, it is vital that staff phrase their questions in a way that encourages honest answers. The honesty of clients' self-reports may be enhanced by using a multiple-choice question format:

***“Which option best describes your smoking activity since your quit date?”***

1. I haven't smoked at all since my quit date, not even a puff
2. I did have the odd puff/cigarette early on in my quit attempt but haven't smoked at all in the last 2 weeks, not even a puff
3. I have had the odd cigarette/puff in the last 2 weeks
4. I am still smoking but have cut down
5. I am still smoking as much as before my quit date

## Intervention type

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

**Where a client has used more than one intervention type or setting, count only the main one ('main' is defined as the one that is recorded the most). If this is not possible, use the one recorded at the contact when the quit date was set.**

All one-to-one interventions should have a total minimum potential client contact time of 1 hour 50 minutes, from the pre-quit preparation appointment through to the four-week post-quit appointment.

**Behavioural support sessions (minimum support for the first six weeks)**

Session	Minimum time allocated (minutes)
Session 1: Pre-quit	30
Session 2: Quit date	20
Session 3: 1 week post-quit	15
Session 4: 2 weeks post-quit	15
Session 5: 3 weeks post-quit	15
Session 6: 4 weeks post-quit	15
<b>Total</b>	1 hour 50 minutes

**Note:** Further sessions may be provided as per local protocol. Clients will need to be able to access the full course of their chosen stop smoking medicine.

The initial pre-quit session is likely to be the longest, and a minimum of 30 minutes should be allocated to it, although slightly less time may be required if a client has used the service before.

Group-based interventions should be at least an hour in length, therefore offering a minimum total of six hours' contact time with group members over a six-week treatment period.

Once the smoker has set a quit date and agrees to take part in the behavioural support programme, it is important that they are offered and encouraged to receive weekly support sessions, including carbon monoxide (CO) monitoring and advice on correct and continued use of medication. Whilst venues and appointment times can be flexible, the client must be advised to attend regularly to get the maximum benefit.

The following table contains pragmatic definitions of the intervention types commonly delivered by local services.

**Table 5: Intervention types**

Intervention type	Evidence rating	Definition
<b>Closed-group</b>	A	A face-to-face intervention facilitated by one or more stop smoking practitioners 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 7.00 pm–8.00 pm for six to seven weeks). To account for diminishing client returns, a minimum of eight members is recommended to start a closed-group.
<b>One-to-one</b>	A	An intervention between a single stop smoking practitioner and a single smoker, at a specified time and place. It is usually delivered face to face, although advances in communication technology have made remote appointments possible.

Intervention type	Evidence rating	Definition
<b>Proactive telephone support</b>	A	An intervention delivered by a stop smoking practitioner over the phone that follows the same specification as one-to-one support.  There should be local pathways in place to ensure that CO monitoring can still be carried out and access to stop smoking pharmacotherapy on prescription is available throughout the treatment episode.
<b>Text-based telephone support</b>	B	Support provided via text. <sup>q</sup>
<b>Open (rolling) group</b>	B	A face-to-face intervention facilitated by one or more stop smoking practitioners with a number of smokers who are at different stages of their quit attempt, at a specified time and place. <sup>r</sup>
<b>Reactive telephone support</b>	B	Ongoing behavioural support provided over the phone, either in between treatment sessions or after the behavioural support programme has ended, in response to calls from clients. Only trained stop smoking practitioners should deliver this intervention.
<b>Online</b>	B	Behavioural support provided over the internet.  A rapid review of the evidence in this area concluded that online support for smoking cessation can be acceptable to users, is of superior efficacy to other wide-reaching interventions and of similar efficacy to face-to-face interventions. <sup>46</sup> A number of other systematic reviews on electronic aids for cessation have reached similar conclusions. <sup>35</sup>  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 four-weeks post-quit.  A new area of intervention is stop smoking applications (apps) available online and via mobile devices. There is limited research to date on stop smoking apps, but a recent content analysis of some available products suggests that very few follow available guidelines for smoking cessation interventions. <sup>47</sup> Newer apps may be promising, but further research is needed before they can be routinely recommended.

q A Cochrane review<sup>46</sup> of mobile phone-based interventions for smoking cessation concluded that the current evidence shows no effect of such interventions on long-term outcome. Whilst short-term results (six weeks) were more promising, the review concluded that more rigorous studies of the long-term effects of mobile phone-based interventions are needed.

However, in 2011 a trial using six-month biochemically validated outcomes was published, providing greater confidence about the efficacy of text-based support.<sup>47</sup> Abstinence at six months significantly increased in the active group (txt2stop) compared to the control group, suggesting that text-messaging support to stop smoking in the UK is effective.

r Recent analysis of routine monitoring data from a sample of services in England has shown that rolling groups achieve better outcomes than a range of one-to-one support options, even after controlling for relevant client and service characteristics.<sup>48</sup> This suggests that open (rolling) groups may be a particularly promising form of behavioural support, but further evidence is required before an A rating can be awarded.



Intervention type	Evidence rating	Definition
<b>Drop in</b>	I	A 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 10.00 am and 12.00 pm).  Clients have the opportunity to be seen individually by a stop smoking practitioner and opportunistic peer support can be realised by providing a waiting area conducive to conversation. <sup>5</sup>
<b>Couple / family support</b>	I	Usually a face-to-face intervention between a stop smoking practitioner, a smoker and up to a maximum of six family members or friends.

### 3. Delivering interventions

All interventions should be delivered by NCSCT<sup>t</sup> certified practitioners, who should follow the intervention principles on page 29.

Currently, the majority of services adhere to the abrupt model that requires a smoker to set a quit date with a trained practitioner and commit to the 'not-one-puff' rule after that date. The NCSCT has developed a Standard Treatment Programme for the delivery of behavioural support for abrupt quit attempts: (see [www.ncsct.co.uk/publication\\_ncsct-standard-treatment-programme.php](http://www.ncsct.co.uk/publication_ncsct-standard-treatment-programme.php)).

#### Assessing nicotine dependence

Assessing an individual's dependence on nicotine can help predict the severity of withdrawal symptoms that they may experience and can indicate the most appropriate type of medication and level of behavioural support required.

#### Quantitative approach

**Evidence rating:** **A**

Cigarette consumption alone is not a good indicator of dependence, as it does not take into account the different ways in which and the intensity with which people smoke their cigarettes. For example, smokers who cut down the number they smoke often continue to get the same amount of nicotine by taking deeper and more frequent puffs, smoking more of each cigarette or blocking the vent holes. This is often referred to as compensatory smoking.

The Fagerström test for cigarette dependence (FTCD)<sup>49</sup> provides a quantitative measure and is the most widely used. It consists of six questions. Scores for each answer are in brackets, and the higher the score the more nicotine dependent clients are.

s Two studies<sup>37,48</sup> of routine monitoring data from a sample of services found a drop in support to be less effective than some other forms of behavioural support, particularly closed-groups. However, further research is needed before the evidence rating for this type of intervention can be changed from I.

t The National Centre for Smoking Cessation and Training was established in 2009. The NCSCT was originally funded by the Department of Health and subsequently part-funded by Public Health England to provide the national training and certification for stop smoking practitioners in England. More information about the NCSCT can be found at [www.ncsct.co.uk](http://www.ncsct.co.uk)

### The Fagerström test for cigarette dependence

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

- After 60 minutes (0)
- 31 to 60 minutes (1)
- 6 to 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 to 20 (1)
- 21 to 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)

### 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 adequate to use just these two questions as a shortened version of the FTCD, called the Heaviness of Smoking Index. As with the full FTCD, the higher the score the greater the level of nicotine dependency.

### Shortened FTCD

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

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

#### 2. How many cigarettes per day do you usually smoke?

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

### 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.

### Biochemical markers of smoking status

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 (CO)

**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 to provide, as a minimum, 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.

A CO reading of or below 10ppm is counted as that of a non-smoker.

The 10ppm threshold for a non-smoker has been questioned, with many considering this to be too high. However, an analysis of stop smoking data completed in 2013 concluded that reducing the threshold would have a minimal effect on success rates, unless the threshold were reduced substantially (e.g. to 3ppm or less), which would probably increase the error of measurement.<sup>50</sup>

CO monitoring is one of the evidence-based behavioural support techniques that can be highly motivating for clients. To achieve as accurate a reading as possible, clients should be asked to hold their breath for 15 seconds (10 seconds minimum) before blowing into the CO monitor.

For those clients not able to complete CO testing due to a physical inability to hold their breath for 15 seconds (e.g. those with COPD), there is still an advantage in completing the test, although 10 seconds is the minimum needed to obtain an acceptable figure. Such clients may need to practise holding their breath, as often it is the uncomfortable feeling associated with breath-holding that makes clients think that they cannot do it for 15 seconds. There is a general national expectation that a minimum of 85% of self-reported four-week quitters undertake (and not just attempt) expired CO validation. The national average in 2013/14 was 70%.<sup>9</sup>

### Calculation for the percentage of CO-verified clients for all quit dates set

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

#### Example: All treated smokers

Treated smokers	Self-reported 4-week quitters	No. of self-reported 4-week quitters CO-verified	Percentage of all treated smokers CO-verified
255	136	89	$89 \div 255 = 35\%$

### Calculation for the percentage of self-reported four-week quitters who have been CO verified

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

#### Example: All self-reported four-week quitters

Treated smokers	Self-reported 4-week quitters	No. of self-reported 4-week quitters CO-verified	Percentage of all 4-week quitters CO-verified
255	136	89	$89 \div 136 = 65\%$

### Monitoring carbon monoxide levels effectively

A survey of CO verification within stop smoking services showed that provision varies greatly.<sup>51</sup> As a result, it made the following recommendations:

- All stop smoking practitioners must have access to a functioning CO monitor at every consultation. Systems should be in place to ensure that CO monitors are calibrated according to the manufacturer's instructions
- In line with the NCSCT training standards, all training should stress the different uses of CO measurement at different time points (including using it as a motivational and reinforcing intervention) and emphasise the importance of verifying self-reported smoking status at the four-week post-quit point

- Stop smoking services require 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 providers under contractual arrangements if a full monitoring form is completed and submitted to the commissioner. The stipulation that follow-up at four weeks is to be conducted with all clients should be written into the contract. 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 asked and encouraged to attend for CO verification

### Carbon monoxide monitoring in pregnancy

There are specific recommendations for CO monitoring in pregnancy that were initially set out in the 2010 NICE guidance on smoking cessation in pregnancy<sup>18</sup> and reviewed and updated in a recent report on cessation in pregnancy developed by a range of organisations.<sup>52</sup>

All pregnant women should be offered a CO test at maternity booking and those identified as smokers should receive a routine referral to their local stop smoking service. Due to the heightened consequences of failing to identify pregnant women who smoke, an appropriate cut-off point for CO testing in pregnancy is lower than for the general adult population, and two recent studies have suggested that this should be 4 ppm.<sup>53,54</sup>

Pregnant women referred to services should be contacted as soon as possible after referral, ideally by a trained practitioner. CO testing should be offered throughout a pregnant woman's quit attempt to monitor abstinence and serve as a motivational tool.

The Public Health Outcomes Framework indicator for smoking in pregnancy is measured as smoking status at time of delivery. All women should be offered a CO test at this time and the smoking status should be recorded in the woman's handheld record as well as on the electronic reporting system. This is a mandated return to the Department of Health and as such it is important that it is reported as accurately as possible.

### Carbon monoxide poisoning

A client may exhibit abnormally high expired CO levels (70ppm+) which could in exceptional cases be due to heavy smoking, or could be due to other causes such as leaking car exhausts or faulty gas appliances. In such cases, they should be given advice about possible CO poisoning, advised to attend Accident and Emergency if needed and encouraged to call the Health and Safety Executive on 0800 300 363.

Further information about CO poisoning is also available on the NHS Choices website (see [www.nhs.uk/conditions/carbon-monoxide-poisoning/Pages/Introduction.aspx](http://www.nhs.uk/conditions/carbon-monoxide-poisoning/Pages/Introduction.aspx)).

## Cotinine

**Evidence rating:** **A**

Cotinine is a metabolite of nicotine produced when nicotine is broken down in the body and it can be detected in the blood, urine or saliva. Whilst CO monitoring is currently the most cost-effective method of validating four-week quits, specific projects or groups may require more specific monitoring using either urinary or salivary cotinine samples, such as in clinical studies, for example.

However, cotinine testing does not allow instant feedback for clients as samples need to be laboratory tested, and therefore it cannot be used as a motivational tool. In addition, the test cannot differentiate between nicotine from tobacco and nicotine from NRT and can therefore be unreliable as a marker of smokefree status where NRT is being used.

## Licensed pharmacotherapy

The stop smoking medicines currently licensed are NRT, bupropion (Zyban) and varenicline (Champix). Varenicline and combination NRT offer smokers the best chances of quitting and should be available as first-line treatments to all clients unless clinically contraindicated.

Summary of Product Characteristics (SPCs) for all medications can be found on the emc website (see [www.medicines.org.uk/emc](http://www.medicines.org.uk/emc)).

Information regarding pharmacotherapy budgets and best practice recommendations can be found on page 32.

## Factors affecting the metabolism of nicotine

Certain factors, including gender, pregnancy and use of oral contraceptives, can increase the rate at which nicotine is metabolised.

People who have a raised metabolism of nicotine will require higher doses of NRT to achieve the same effects upon cravings and other withdrawal symptoms. This is especially true for pregnant women (who can metabolise nicotine by up to 60% faster than when not pregnant), who may need higher doses of NRT. Where appropriate, stop smoking practitioners should advise pregnant women to use NRT in line with the product specification and should be especially careful about this client group under-dosing or stopping the treatment early.

**Table 6: Factors that can affect the metabolism of nicotine**

Factor	Effect
<b>Gender</b>	Women metabolise nicotine 15% faster than men
<b>Pregnancy</b>	Pregnant women metabolise nicotine up to 60% faster <sup>55</sup>
<b>Oral contraceptive</b>	Women using an oral contraceptive metabolise nicotine 40% faster <sup>56</sup>

## Nicotine replacement therapy

**Evidence rating:** **A**

NRT is safe and effective. When provided by a healthcare professional and used without additional behavioural support it approximately doubles the chances of long-term abstinence.<sup>57,58</sup>

There are eight different types of NRT: patch (24 hr and 16 hr), gum, lozenge (including mini-lozenge), microtab, nasal spray, mouth spray, oral strip and inhalator.

For further information about the NRT products, refer to the summary of product characteristics (SPCs) available at <http://emc.medicines.org.uk>.

There is no evidence to suggest that one type of NRT is significantly more effective in practice than another, although further academic analysis has found that abstinence is significantly higher for lozenges compared to gum and that the nasal spray is slightly more effective than lozenges (see Table 7). Product selection should be guided by client preference.

**Table 7: Effectiveness of different forms of nicotine replacement therapy<sup>57</sup>**

Form of replacement	RR*	95% CI	Trials, n
<b>Any form</b>	1.60	1.53–1.68	–
<b>Nasal spray</b>	2.02	1.49–2.73	4
<b>Tablets / lozenges</b>	1.95	1.61–2.36	6
<b>Inhalers</b>	1.90	1.36–2.67	4
<b>Patches</b>	1.64	1.52–1.78	43
<b>Gum</b>	1.49	1.40–1.60	55

\*RR = risk ratio of abstinence relative to control

## Combination therapy

**Evidence rating:** **A**

Using a combination of NRT products (combination therapy) has been shown to have an advantage over using just one product,<sup>57</sup> increasing the chances of quitting by up to 35%. It is also considered cost-effective and should be available as part of standard treatment.<sup>22</sup>

It is recommended that a nicotine patch is used to help with 'background' urges to smoke, combined with a faster-acting product (e.g. the mouth spray, lozenge) to top up the dose of nicotine and to assist with 'breakthrough' urges to smoke.

### Nicotine replacement therapy with special population groups

NRT can be used by adolescents aged 12 and over, pregnant women and people with cardiovascular disease.

## Nicotine replacement therapy in pregnancy

### Evidence rating: **C**

There is currently insufficient evidence available on the effectiveness of NRT in helping pregnant women to stop smoking.<sup>59</sup> The Smoking, Nicotine and Pregnancy (SNAP) trial did not find significant differences in cessation rates between women who used NRT and those provided with a placebo, raising important questions about the efficacy of standard-dose single-product NRT in pregnancy. However, many women in the trial did not use NRT consistently at a high enough dose or for sustained periods, making recommendations for practice from this trial difficult.<sup>60</sup>

The Medicines and Healthcare Products Regulatory Agency (MHRA) recommends that pregnant women should try to stop smoking without using NRT. If this is not possible then NRT may be recommended as the risk to the foetus of continued smoking by the mother far outweighs any potential adverse effects of NRT.<sup>61</sup>

This seems an overly conservative view for a smoking population for whom time is of particular importance. Clinical good practice and expert opinion indicate that women should not need to fail to quit before being offered access to stop smoking medications. NRT should be made available in the first instance, and it is advised that the shorter-acting oral products, rather than nicotine patches, are used initially. However, data from English stop smoking services suggests that the use of combination therapy with pregnant smokers is more effective than single-dose NRT.<sup>62</sup>

NICE recommends that NRT can be used by pregnant women as long as stop smoking practitioners discuss the risks and benefits of NRT with the client, using their professional judgement when deciding whether to offer a prescription to those who express a clear wish to receive NRT.

### Nicotine replacement therapy use by people with mental illness

NRT is also effective for people with a mental illness<sup>63</sup> and, given that such clients are typically more nicotine dependent, the amount of NRT required is likely to be higher than that needed for smokers in the general population.

NRT can double cessation rates and lower self-reported depression in depressed smokers.<sup>64</sup> Nicotine replacement is effective for people with schizophrenia, although not as effective as it is for the general population.<sup>65</sup> There is some evidence that the rapid nicotine delivery of a nasal spray is most successful<sup>66</sup> and cessation rates are likely to be enhanced when a fast-acting method of delivery is combined with nicotine patches.



## Nicotine-Assisted Reduction to Stop (NARS) and preloading

**Evidence rating:** **B**

This approach involves following a structured programme of cutting down with NRT over a relatively short time period (e.g. six weeks) leading up to a quit date, and is an alternative approach that can be used with smokers who may be unwilling or unable to stop in one step. There is very little evidence as to what constitutes the best clinical approach for NARS, but NICE public health guidance on tobacco harm reduction (PH45) provides further detail on the evidence behind this approach, including that using NRT whilst reducing smoking increases the likelihood of long-term abstinence<sup>67</sup> and the odds of cessation<sup>68</sup> (see Annex I).

There is also emerging evidence that preloading, using NRT for a short period (e.g. two to four weeks) before a quit attempt, results in higher cessation rates.<sup>58,69</sup>

## Varenicline (Champix)

**Evidence rating:** **A**

A prescription-only drug, varenicline has been shown to increase the chances of long-term abstinence two-to-threefold<sup>70</sup> when compared to using no medication. Three RCTs have shown it to be more effective than bupropion,<sup>70</sup> which in turn is more effective than single-dose NRT. Varenicline is a safe drug with no drug interactions and a minimal side-effect profile.

For further information about varenicline, refer to the summary of product characteristics (SPC) available at <http://emc.medicines.org.uk>.

### Varenicline use in pregnancy

Varenicline is not licensed for use in pregnancy or when breastfeeding.

### Varenicline and mental illness

Varenicline is not contraindicated for use in those with mental disorders. Depression, suicidal thoughts, suicide attempts and completed suicides have been reported in people taking varenicline who have no pre-existing psychiatric conditions.<sup>71</sup> However, it should be noted that there is no evidence that varenicline is associated with an increased risk of depression or suicidal thoughts. The MHRA cautiously advises particular care in patients with a previous history of psychiatric illness, and states that patients, family members and caregivers should be advised accordingly.

The following appears within the SPC for varenicline:

Changes in behaviour or thinking, anxiety, psychosis, mood swings, aggressive behaviour, 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 or thinking that are of concern for the doctor, the patient, family or caregivers are observed, or if the patient develops suicidal ideation or suicidal behaviour. In many post-marketing cases, resolution of symptoms after discontinuation of varenicline was reported although in some cases the symptoms persisted; therefore, ongoing follow up should be provided until symptoms resolve.

Depressed mood, rarely including suicidal ideation and suicide attempt, 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).

Close regular monitoring by stop smoking practitioners, psychiatrists, GPs and community health staff should occur through a clearly negotiated plan of support, with clear strategies for responding in the event of changes, especially in the first 2–3 weeks.

Two briefings regarding varenicline are available on the NCSCT website:

**Varenicline: effectiveness and safety:**

[www.ncsct.co.uk/publication\\_Varenicline\\_effectiveness\\_and\\_safety.php](http://www.ncsct.co.uk/publication_Varenicline_effectiveness_and_safety.php)

**Cardiovascular disease and varenicline:**

[www.ncsct.co.uk/publication\\_cardiovascular\\_disease\\_and\\_varenicline.php](http://www.ncsct.co.uk/publication_cardiovascular_disease_and_varenicline.php)

## Bupropion (Zyban)

**Evidence rating:** **A**

Bupropion is an antidepressant medication that can almost double the chances of long-term abstinence.<sup>72</sup> It is a prescription-only medication and should not be used in combination with any other stop smoking medications. There is no evidence to show whether bupropion is less or more effective than single NRT, although three randomised controlled trials (RCTs) have shown it to be less effective than varenicline for long-term abstinence.<sup>70</sup>

### Cautions and adverse effects

Although a safe medication, bupropion does have a relatively serious side-effect profile and a number of contraindications and cautions. For further information about bupropion, including a full list of the cautions and contraindications, refer to the summary of product characteristics (SPC) available at <http://emc.medicines.org.uk>.

### Bupropion use in pregnancy

Bupropion is not licensed for use in pregnancy or when breastfeeding.

### Effect of cessation on medications

Cigarette smoke (not nicotine) stimulates a liver enzyme responsible for metabolising some drugs, which means that some medications are eliminated from the body quicker by smokers than by non-smokers. This can mean that the dose of some medications needs to be reduced following smoking cessation.

Some medications have a narrow therapeutic window, meaning too small a dose will be ineffective and too much will be toxic. If a person stops smoking, then their regular dose of a medication (if calculated before stopping) could cause toxicity<sup>63</sup> or a significant increase in side effects from that medication.

Medicines affected in this way include, but are not restricted to, theophylline, insulin, paracetamol, propranolol, tamoxifen, verapamil and warfarin-R as well as some medicines for mental illness:

- Antidepressants: tertiary tricyclics (e.g. amitriptyline, clomipramine, desipramine, imipramine), fluvoxamine (partly), mirtazapine (partly)
- Antipsychotic medication: clozapine, fluphenazine, perphenazine, haloperidol (partly), olanzapine (partly)
- Benzodiazepines: diazepam, zotepine
- Opiates

### Best practice recommendations

- Client medical information and current medication should always be sought and recorded during the first stop smoking appointment
- There should be a protocol in place for instances when further advice or onward referral is required (e.g. where a possible caution or interaction is identified following a cross-check of clients' medical history and/or other medication use against a list of contraindications or cautions for a medicine)
- The GP and other professionals (such as key mental health worker) of any client using medications that may be affected by cessation should be informed of the quit attempt so that dosage can be reviewed and adjusted. This is of particular importance when a service user is transferred between treatment settings, as a recent change in smoking status (e.g. having quit, significantly cut down or relapsed) may not be immediately picked up
- Quit status should be regularly reassessed and, if the client relapses, prescribers should again be made aware to ensure appropriate readjustment of dose

## Unlicensed nicotine containing products (nicotine vapourisers)

**Evidence rating:** **C**

See page 23.

Further information about nicotine vapourisers (e-cigarettes) can be found here:

**ASH briefing on e-cigarettes** (see [www.ash.org.uk/files/documents/ASH\\_715.pdf](http://www.ash.org.uk/files/documents/ASH_715.pdf))

**NCSCCT briefing on e-cigarettes** (see [www.ncsct.co.uk/publication\\_ecigarette\\_briefing.php](http://www.ncsct.co.uk/publication_ecigarette_briefing.php)).

## 4. Priority population groups

Smoking cessation interventions tailored for people from disadvantaged groups may be slightly more effective than generic interventions aimed at these groups. However, it is unlikely that tailored interventions alone have a significant impact on the social gradient in smoking prevalence. It is important to ensure that stop smoking services are easily accessible by people from these groups and that they are encouraged to use them.<sup>2</sup>

Local intelligence can be used to identify the priority groups within an area (see page 13). This section highlights a number of potential groups.

### Routine and manual smokers

**Evidence rating:** **B**

Historically, the decline in smoking rates amongst higher-income groups has been greater than amongst lower-income groups; higher smoking rates are still observed in routine and manual (R/M) groups, lower socio-economic groups, and certain minority and vulnerable groups compared with the general population. People working in routine and manual occupations form the largest group of smokers amongst the general population.

### Research insights into groups of disadvantaged and routine and manual smokers

Smoking is strongly associated with social deprivation, and higher levels of tobacco use and addiction are often found in the most disadvantaged areas.<sup>73</sup> People living in these areas, however, are just as likely to want to quit as affluent smokers.<sup>74</sup>

Barriers to accessing effective stop smoking services may have contributed to the slower decline in prevalence in this group, although it is more likely that issues such as greater levels of addiction and poorer life circumstances are key.

A number of studies have sought to understand barriers to accessing services and to explore how they can be overcome. A study<sup>75</sup> using focus groups made up of 39 socio-economically deprived smokers concluded that these smokers had a fear of being judged and a fear of failure, and demonstrated a lack of knowledge about services and the medication available. It was recommended that services be promoted in a personalised, non-judgemental and flexible manner to address these issues. A further study<sup>76</sup> involving interviews with 100 disadvantaged smokers in Edinburgh investigated their perceptions of smoking and past experiences of quit attempts. It 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.

Smokers in more deprived groups are just as likely as those in higher groups to try to stop and to use aids to cessation. However, there is a strong gradient across socio-economic groups in relation to the success of quit attempts; those in the lowest group are half as likely to succeed compared with those in the highest.<sup>77</sup> The inferior quit rates amongst lower socio-economic groups can partially be explained by their higher levels of nicotine addiction (observed by higher nicotine dependence scores) as nicotine dependence predicts failure of attempts to stop smoking. However, other factors have a role to play, and smokers in more deprived groups 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.<sup>78</sup>

Other research with stop smoking service clients found that encouraging smokers to adhere to the treatment programme (to keep attending appointments and to use pharmacotherapy correctly and for long enough) may be particularly helpful in supporting more disadvantaged smokers to quit.<sup>78</sup>

### Working with routine and manual employers

Table 8 below gives an overview of the occupations commonly associated with the R/M population and an indication of the number of people employed in these occupations.

**Table 8: Routine and manual occupations (estimated numbers in England)**

Male R/M occupations	Female R/M occupations
Transport and haulage (363,000 are HGV drivers)	Sales and retail (884,000)
Construction (169,000 labourers, 139,000 construction trades)	Carers (581,000)
Manufacturing (139,000 in metal work and maintenance)	Cleaners / domestic staff (549,000)
Sales and retail (233,000)	Educational assistants (295,000)
Other blue-collar trades (174,000 van drivers, 154,000 carpenters)	Kitchen / catering (288,000 assistants, 113,000 chefs / cooks)
Security (156,000 security guards)	Receptionists (220,000)
	Hairdressers (109,000)

### Secondary care

#### Evidence rating: **A**

A recent Cochrane review reported that delivering stop smoking services to inpatients 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 in helping patients to quit.<sup>20</sup>

Pre-operative smoking cessation can significantly reduce the risk of post-operative cardiac and pulmonary complications and the duration of the hospital stay, as well as decrease the risk of wound infection and delayed wound healing. In addition, long-term abstinence reduces the risk of developing new diseases<sup>79</sup> and has been associated with a decreased risk of disease progression.<sup>80,81</sup>

Admission to hospital offers an opportunity for a teachable moment<sup>20</sup> as people are more receptive to health advice and support whilst they are in a healthcare setting. In line with the Making Every Contact Count agenda, health professionals should use this period of heightened motivation to stop smoking to offer VBA, encourage smokefree compliance and highlight any need for withdrawal management.

### NICE guidance for secondary care (PH48)

NICE published new public health guidance in November 2013 specifically for secondary care.<sup>82</sup> The guidance clearly sets out how to support people using acute, maternity and mental health services to stop smoking and makes a range of recommendations on effective actions. These include promoting cessation in advance of planned admissions, provision of stop smoking medicine and behavioural support immediately following admission, and instigation of smokefree policies that prohibit smoking in both buildings and grounds.

This NICE guidance signifies a huge step forward for smoking cessation in secondary care settings as it gives specific recommendations on how to achieve and initiate a cultural change. This guidance places NHS hospital trusts at the centre of the patient's journey, highlighting their unique position in supporting people who smoke to quit before, during or after a hospital stay. The overall aim of the guidance is to embed the delivery of very brief Advice (VBA) into routine clinical care and to reinforce the message to staff that they have a clinical duty to do this.

The guidance states that NHS hospitals should provide everyone with verbal and written information about the hospital's smokefree policy before their appointment, procedure or hospital stay. This should include information about the short- and long-term benefits of stopping smoking and details of the support available to help them stop. A clinical or medical director should be assigned to lead on smoking cessation and smokefree policies for the organisation, promoting support for patients and staff who want to quit, prohibiting staff-facilitated patient smoking breaks and banning the sale of tobacco products in secondary care settings. They should also ensure smokefree plans include the removal of shelters or other designated outdoor smoking areas, as well as ensuring that staff, contractors and volunteers are not allowed to smoke during working hours, when in uniform or on hospital business.

### Recommendations

- All front-line hospital staff should be trained to provide VBA to every smoker. This should be agreed as mandatory training, be part of all staff induction and be included in front-line staff personal development plans
- All patients should receive VBA on admission to hospital and be referred for more intensive support from their local stop smoking service
- All smokers' nicotine dependency levels should be assessed following admission and NRT provided as soon as possible for withdrawal management
- At pre-operative assessment, patients who do not intend to stop smoking prior to surgery should be advised of the hospital's smokefree policy. Pharmacotherapy should be offered to assist with withdrawal management and be provided through primary care
- CQUIN contracts (where negotiated with the CCG) or similar-quality indicators can be an effective lever to embed systems of providing VBA and referral to local stop smoking services within secondary care

- Stop smoking service providers should be prepared to support patients who have stopped 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. Should the patient not have stopped smoking during their hospital stay, they should be given VBA again on discharge

### Case study: Implementation of the National Referral System in Peterborough and Stamford Hospitals NHS Foundation Trust

The NCSCT National Referral System (NRS) is designed to embed routine identification and referral of smokers within secondary and primary care settings, and to date it has processed over 10,000 referrals to local stop smoking services. The system includes:

- Online very brief advice training for all staff
- An electronic referral system that links to the existing IT programmes used within the secondary or primary care setting
- Strategic and operational project management
- Reportable outcomes

In 2013, Peterborough and Stamford Hospitals NHS Foundation Trust implemented the system to increase the amount of referrals received from the hospital to their local Live Healthy Smokefree Service.

The implementation process involved the development of a project group to monitor and oversee implementation. The NCSCT provided the structure and milestones for implementation, but having high level trust commitment for the project from the outset ensured that the project progressed smoothly and successfully. A service level agreement (SLA) was developed between the key stakeholders that clearly outlined roles and responsibilities. The implementation commenced in May 2013, and the system was live by July that year.

#### Outcomes

- From 20th July 2013 (launch date) to the end of March 2014 a total of 591 referrals to stop smoking services were made. In 2012/13, before the NRS was implemented, only 16 referrals were received by the local stop smoking service, with no quits
- Of these, 365 were patients resident within the locality and 226 were referred to other stop smoking services. Of the 365 accessing the local service, 25% (n=90) set a quit date and 76 quit (an 84% conversion rate)
- The project helped to establish positive relationships between key hospital departments, helping to ensure that the NRS continues to be supported and promoted
- Development of smoking champions supports the hospital to see smoking as a key priority
- Extended knowledge of the risks of smoking to patients, and hospital staff understanding VBA and the referral system

For further information about the NRS contact [enquiries@ncsct.co.uk](mailto:enquiries@ncsct.co.uk)

## Pregnancy

### Evidence rating: **B**

The impact of smoking during pregnancy on maternal and foetal health is significant in terms of morbidity, mortality and healthcare costs. Babies born to women who smoke during pregnancy are around 40% more likely to die within the first four weeks of life than babies born to non-smokers.<sup>83</sup>

Smoking during pregnancy can result in increased risk of miscarriage, preterm birth, low birth weight and stillbirth. It is associated with sudden unexplained death in infancy, childhood respiratory illnesses, attention deficit hyperactivity disorder<sup>84–86</sup> and behavioural problems in children.<sup>87,88</sup>

The total annual cost to the NHS of smoking during pregnancy is estimated to be up to £64 million for treating the resulting problems for mothers, and could be as high as £23.5 million for treating the infants (aged 0–12 months) of women who smoked during pregnancy.<sup>89</sup> Estimates have placed the costs of a complicated delivery by a smoker at 66% higher than those of a non-smoker.<sup>90</sup> Smoking in pregnancy, therefore, remains a key public health concern, particularly since early intervention (i.e. stopping prior to three months gestation) significantly improves outcomes.<sup>91</sup>

In 2013/14, 19,865 pregnant women set a quit date with local stop smoking services. Nearly half (47%) were self-reported quits at four weeks and 57% of these were CO-validated quitters.<sup>9</sup>

However, increased social pressure and stigma reduce the reliability of self-reported smoking status in pregnant smokers, and biochemically validated prevalence rates amongst this population have been found to be significantly higher than self-reported prevalence.<sup>92</sup> Therefore every effort should be made to biochemically validate and record smoking status in pregnancy (see page 53).

### NICE Public Health Guidance 26:

#### *How to stop smoking in pregnancy and following childbirth*

The 2010 NICE Public Health Guidance *How to stop smoking in pregnancy and following childbirth*<sup>18</sup> sets out eight recommendations for action. These recommendations were reinforced by a 2013 report that emphasised the importance of the implementation of NICE guidance in this area (see [www.ash.org.uk/files/documents/ASH\\_893.pdf](http://www.ash.org.uk/files/documents/ASH_893.pdf)).

#### **NICE recommendations 1 & 2: Identification and Referral of Pregnant Smokers**

The guidance recommends actions for the identification of all pregnant women who smoke and for referral to stop smoking services. At the first maternity booking, and at subsequent appointments, midwifery staff should assess the woman's exposure to tobacco smoke, use a biochemical test (i.e. CO monitor) to confirm and record smoking status, and refer if appropriate to the local stop smoking service. The guidance also advocates that those responsible for providing health and support services for pregnant women should use any appointment or meeting as an opportunity to deliver VBA.



### Case study: Implementation of the babyClear approach to routine identification and referral of pregnant smokers across County Durham and Darlington Foundation Trust (FT)

The babyClear system is a regional approach, supported by Fresh, to tackle the high rates of maternal smoking across the North East of England. It was developed to embed routine identification and referral of pregnant smokers into stop smoking services by midwifery staff. County Durham and Darlington FT was the first Trust to fully roll out this approach in the North East. This involved:

- 120 midwives / midwifery staff being trained in a standardised three-minute intervention at booking. As part of this training, they received carbon monoxide monitors and all associated leaflets / resources. CO monitors are uniquely numbered to allow tracking of referral rates
- 10 stop smoking service administrative staff attending a one-day lead management training session
- 33 stop smoking practitioners who work with pregnant smokers attending a two-day skills training course
- 15 midwives being trained to deliver a more intensive risk perception intervention at the 12-week dating scan, highlighting the risks of continued smoking in pregnancy

Implementation involved regular meetings with key strategic partners, including the head of midwifery, senior midwifery staff and stop smoking service commissioners and providers; formal approval was also obtained from the trust's Chief Executive to adopt this approach. The local stop smoking service pregnancy lead manages the day-to-day process locally following implementation, ensuring that all midwives are routinely using their CO monitors at booking and are providing training updates.

#### Key early outcomes locally:

- From full local roll-out of babyClear to the end of quarter 2, 2013–14, the stop smoking service saw a 41% rise in the number of quit dates set by pregnant women, in comparison to the previous year
- This converted to a 43% year-on-year rise in the number of successful, pregnant four-week quitters over that same period
- Over 2013–14 as a whole, the Durham Stop Smoking Service received over 1,870 referrals of pregnant smokers, which represented 45% of all referrals into the service that year
- The risk perception intervention at dating scan (aimed at smokers who had declined support previously) has seen one in seven of referred women successfully quitting with the local stop smoking service

Newcastle and Teesside Universities are conducting a long-term evaluation of the project that will look at the impact of babyClear on birth outcomes and staff attitudes.

**Case study:** *continued***Key learning points:**

- Securing the highest levels of strategic support within the trust can help overcome minor issues, and regular communication between all parties is essential
- Delivery of tailored training sessions for all staff involved in pathway (midwives, practitioners, administrative staff) is vital to improving skills and awareness
- Head of midwifery support is crucial in securing attendance from midwifery staff at training. Basic sessions should last no more than two hours
- Standard approach to biochemical intervention at booking is pivotal in making sure that key messages are delivered consistently but quickly. Interventions should last no more than three minutes if midwives are to incorporate them into their booking routine
- Genuine opt-out referral process for all women based on agreed CO levels removes any 'judgement' call by midwife
- Trained midwives delivering harder-hitting messages at subsequent appointments to those women who have previously declined support can be effective
- Importance of overarching strategic project lead, but also 'hands-on' management of the process by the stop smoking service in pregnancy lead locally

**Case study: Increasing engagement with pregnant smokers  
– introduction of the Healthy Pregnancy Support Service (HPSS)  
in Dudley maternity services**

Dudley has a well-established and robust smoking and pregnancy referral process. In 2011–12, 795 women were referred, with 262 women setting a quit date and a 56% quit rate. However, engaging women using texts and phone calls had limited success, with only 43% of referrals agreeing to have at least one face-to-face contact with a practitioner. Historically, a barrier to increasing interventions at point of care has been the lack of midwives' time and therefore meaningful conversations about smoking were never prioritised.

In 2013, the Dudley Public Health Department agreed to fund a pilot in partnership with weight management practitioners who were working alongside community midwives in antenatal clinics. The role of practitioners was to prioritise identification of smokers and offers of support to stop smoking, as well as to give advice on weight management in pregnancy, healthy eating, breastfeeding and healthy-start vitamins. Once smokers were identified, they were offered one-to-one stop smoking support and access to NRT products with follow-up in the home or clinic.

### Case study: *continued*

As part of the contract, HPSS practitioners had to be NCSCT certified and complete the NCSCT *Smoking in pregnancy and Secondhand smoke* specialty modules in addition to attending a face-to-face training day for local implementation. Quarterly performance meetings were held with the senior clinical antenatal midwife manager, community midwifery team leads and the practitioners to discuss any quality or process issues, identify any further training needs and offer support if needed.

#### The pilot objectives were to:

1. Increase access to pregnant smokers
2. Improve recording of smoking status at booking and increase the accuracy of smoking prevalence figures
3. Establish the use of routine CO testing
4. Increase the number of women setting a quit date and successfully quitting throughout pregnancy

#### Outcomes (2013–14)

- 85% of women were CO tested at first contact
- Referrals increased by 22% to 970 for the 12 months
- Face-to-face contacts increased from 43% to 56%
- The number of women setting a quit date increased by 41%
- The number of women successfully quitting at four weeks increased by 23%
- Quit rate fell slightly from 56% to 52%

#### Conclusion

It appears that the initial face-to-face contact with women has a strong influence on breaking down initial barriers about being seen by a specialist smoking and pregnancy practitioner for help to quit. The pilot has increased midwives' knowledge and made CO testing part of routine antenatal care. Involving community midwifery leads in performance management meetings has strengthened their commitment and knowledge. As part of the contract, *Guidelines for The Management of Pregnancy Smokers* was written in conjunction with the Dudley Stop Smoking Service and the maternity unit and ratified to make clear the maternity service's role in reducing smoking at time of delivery. The pilot was deemed successful and public health funding has been agreed with a further 2½ year contract, with an increased number of practitioners.

**NICE recommendation 3 & 4: Actions for stop smoking services**

Stop smoking services should offer pregnant smokers a full range of evidence-based interventions. They should ensure that service provision is proactive and responsive in contacting referrals promptly in order to effectively engage with this client group.

Engaging with pregnant women to help them stop smoking involves communicating in a sensitive client-centred manner, particularly as some pregnant women find it difficult to say that they smoke.

**It is recommended that:**

- Pregnant smokers are provided with intensive and ongoing support throughout pregnancy and in the post-partum period
- When a pregnant woman sets a quit date, the midwife should be informed of the quit attempt through a locally agreed protocol
- Information on the quit attempt, including the type of support provided and the outcomes, should also be given to the appropriate health visitor in the postnatal period
- There should be a robust care pathway in place that allows for tracking of the pregnant smoker through their quit attempt and beyond into the post-partum period; this should be developed in partnership with primary care, the maternity care providers, the community and voluntary sector health and support services

**NICE recommendation 5: Use of nicotine replacement therapy in pregnancy**

See NRT section (page 56).

**NICE recommendation 6: Socio-demographic factors associated with smoking in pregnancy**

NICE recommends that stop smoking service providers take into account other socio-demographic factors such as age and ethnicity of pregnant smokers to ensure that service provision is tailored to meet the individual needs of the local population. There is wide ethnic variation in smoking in pregnancy, and this should be taken into consideration when designing and delivering services. For example, 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 black and minority and ethnic groups in their locality.

Women in routine and manual occupations, and those who have never worked, are five times as likely as those in managerial and professional occupations to smoke throughout pregnancy (20%, 21% and 4% respectively).<sup>93</sup> Stop smoking service providers should therefore continue to target this group of women.

Services should collaborate with the family nurse partnership pilot and other outreach schemes, and work in partnership with agencies that support women who have complex social and emotional needs to identify additional opportunities for providing intensive and ongoing support. This should also include substance misuse services and mental health services.

**NICE recommendation 7: Partners and others in the household who smoke**

There is a strong association between a mother's smoking behaviour during pregnancy and whether or not she lives with other smokers.<sup>93</sup> It is therefore recommended that stop smoking service providers encourage partners and family members who smoke to quit and provide them with intensive ongoing support to help them to stop smoking and remain smokefree. They should encourage partners and others in the household who continue to smoke not to smoke around the pregnant woman, mother or baby, including not smoking in the house or car.

**A free online training module Very brief advice on second-hand smoke:** promoting smokefree homes and cars can be accessed here: [http://elearning.ncsct.co.uk/shs\\_vba-launch](http://elearning.ncsct.co.uk/shs_vba-launch)

**NICE recommendation 8: Training to deliver interventions**

NICE recommends that adequate training be put in place in order for the other recommendations to be possible. This includes training for midwives in how to deliver very brief advice and conduct CO monitoring.

For stop smoking practitioners, a free online *Pregnancy and the Post-Partum* speciality training module is available from the NCSCT to all those who are NCSCT certified.

**Teenage pregnancy**

**Evidence rating:** 

Rates of smoking in pregnancy are higher amongst young women (20 years of age or under); they are more than three times as likely to smoke before or during pregnancy as mothers aged 35 or over and they are less likely to quit smoking during pregnancy.<sup>94</sup> Stop smoking services should ensure that they work in partnership with teenage pregnancy support services, to develop services that meet the needs of this priority group, and they should ensure that they are meeting the *You're Welcome Quality Criteria*.

The *You're Welcome Quality Criteria: making health services young people friendly*<sup>94</sup> report sets out principles that support health services in developing opportunities that young people are more receptive to. The self-assessment toolkit covers areas to be considered by commissioners and providers of health services. The criteria support the implementation of standard four of the National Service Framework for Children, Young People and Maternity Services and build on the Royal College of General Practitioners' initiative *Getting it Right for Teenagers in Your Practice*, which has been supported by the Teenage Pregnancy Unit.

**The report can be accessed here:**

[www.gov.uk/government/publications/quality-criteria-for-young-people-friendly-health-services](http://www.gov.uk/government/publications/quality-criteria-for-young-people-friendly-health-services)

Recommendations for both stop smoking service providers 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*.<sup>95</sup> The baby charity Tommy's has also produced a useful guide on smoking cessation for teenage parents, which is supported by the Department of Health.<sup>96</sup>

## Smoking and mental health

### Evidence rating: **B**

In contrast to the smoking rate of 19.8% in the general population, smoking rates of 32% for those with depressive or anxiety disorder (common mental disorder), 40% for probable psychosis, 46% for alcohol dependence, 69% for illicit drug dependence and 57% for those attempting suicide in the previous year have been reported.<sup>21</sup> Even higher levels of smoking occur within psychiatric inpatient settings, where up to 70% are smokers and 50% heavily dependent smokers.<sup>23</sup> People with a mental disorder are likely to be more dependent on tobacco and to have smoked longer than smokers in the general population.<sup>97</sup>

Due to the numbers affected in the population, those with a mental disorder are responsible for 42% of tobacco consumption in England, with 31% of all tobacco consumption by those with a common mental disorder.<sup>21</sup>

Smoking is responsible for the largest proportion of the excess mortality of people with a mental disorder.<sup>98</sup> Men and women living with schizophrenia in the community have, respectively, a 20- and 16-year reduced life expectancy<sup>98</sup> with, for example, the death rate from respiratory disease amongst people with schizophrenia being three times higher than average.<sup>99</sup>

Smoking tobacco is significantly associated with increased prevalence of all mental disorders,<sup>21</sup> with smokers 50% more likely to suffer from a mental disorder than non-smokers<sup>100</sup> and more than twice as likely to attempt suicide.<sup>101</sup>

It is therefore crucial that people with mental disorders have appropriate access to stop smoking support and are encouraged to stop. A joint report published by the Royal College of Physicians and the Royal College of Psychiatrists, *Smoking and mental health*, provides a comprehensive summary of the evidence and recommendations for practice (see [www.rcplondon.ac.uk/sites/default/files/smoking\\_and\\_mental\\_health\\_-\\_full\\_report\\_web.pdf](http://www.rcplondon.ac.uk/sites/default/files/smoking_and_mental_health_-_full_report_web.pdf)).

### Prevalence of stop smoking service clients with a mental health problem

Since 42% of overall tobacco consumption in England is by people who have a mental health problem, this group is likely to represent a significant proportion of smokers seen by stop smoking services.

The number of clients with a mental health problem who are treated by stop smoking services has previously been unavailable; changes to the data collection in 2014 mean that the proportion of support delivered in mental health settings is now being captured and will be available from 2015.

A survey of services in the London region found that the majority did not routinely check mental health status and that only 11% would be able to provide data on the proportion of service clients with a reported mental health problem.<sup>102</sup> This is an important clinical issue as stopping smoking can result in changes to the metabolism of certain medications and these may require dose changes to maintain safe and therapeutic levels.

It is vitally important from a clinical perspective that service providers routinely ask all clients about any mental disorder diagnoses (Ask); inform relevant health professionals about the quit attempt (Inform), including information regarding the effect of cessation upon any medication being taken (Medication) and tailor the behavioural support programme to meet the needs of the client (Support) (see the AIMS model, Figure 6).

**Figure 6: AIMS procedure for supporting people with mental health problems to stop smoking**



### Stopping smoking and inequality reduction

Since increased levels of smoking are responsible for the largest proportion of health inequality for people with mental disorders, uptake of cessation support will have an even larger impact on health outcomes and reducing health inequalities. However, if investment in stop smoking services for this group does not at least exceed that for the general population then the health inequalities experienced by people with mental disorder will increase.

### Positive effects of stopping smoking on mental health

Evidence suggests that there is a link between the amount smoked and the number of depressive and anxiety symptoms.<sup>103</sup> On stopping, these symptoms are seen to reduce<sup>104</sup> and can be accompanied by a sense of achievement.

There are tangible benefits for mental health when people stop smoking. A recent systematic review and meta-analysis of the change in mental health after smoking cessation concluded that quitting is associated with reduced depression, anxiety and stress and improved positive mood and quality of life compared with continuing to smoke.<sup>105</sup>

### Stopping smoking and depression

In a minority of cases, smoking cessation, with or without pharmacotherapy, is associated with an exacerbation of depression.<sup>106</sup> Stop smoking practitioners should be aware of the possible emergence of depression in clients undertaking a quit attempt, and should advise both patients and the appropriate clinical team accordingly.

### Stopping smoking and schizophrenia

In people with schizophrenia, there is little evidence to show any worsening of symptoms following stopping smoking.<sup>107</sup> Stopping smoking can enable prescribers to reduce the dosages of some medications, which in turn can result in a significant reduction in the side effects associated with higher doses of these medications.

### Stop smoking interventions for those with a mental disorder

A systematic review found that smoking cessation treatments that work in the general population work for those with severe mental illness and appear to be approximately as effective. The same review found that treating tobacco dependence in patients with stable psychiatric conditions does not worsen their mental state.<sup>107</sup>

As with more dependent smokers in the general population, those with a mental disorder, who are likely to be more dependent smokers anyway, often require a combination of more intensive pharmacological and behavioural support. Combining pharmacotherapy with behavioural support can achieve abstinence rates in those with mental health problems similar to those seen in the general population.<sup>108</sup>

For further information see the pharmacotherapy section on page 54.

Up to now, people with a mental health disorder have been less likely to receive stop smoking interventions in primary care.<sup>109,110</sup> NICE public health guidance PH48<sup>82</sup> provides recommendations to support smoking cessation, temporary abstinence from smoking and smokefree policies in all secondary care settings, including for mental health.

Anyone involved in providing a structured smoking cessation programme should be fully NCSCT certified and have attended face-to-face training that meets the national training standard. The NCSCT also provides a free online *Smoking and Mental Health Specialty Module* that is accessible to those who have achieved NCSCT certification.

A pilot project undertaken by the UK Centre for Tobacco and Alcohol Studies inside mental health inpatient settings<sup>111</sup> provided the following recommendations:

- Mental health trusts should ensure the comprehensive recording of smoking-related information through the mandatory recording of patient smoking status, the introduction of smoking-specific documentation and smoking-related targets (CQUIN)
- Mental health trusts should develop comprehensive guidelines for staff to ensure mental health patients are provided with a flexible tobacco dependence programme which can be tailored to the needs of individual patients
- Each mental health trust should have clear referral pathways between different treatment settings to ensure the continuity of tobacco dependence support



- Each mental health trust should employ a tobacco dependence practitioner, or provide protected time for existing staff, to provide stop smoking support services. The employment of one practitioner who could cover both community and inpatient settings on a full-time basis and train staff to ensure continuous and sustainable support would appear to be an efficient model of service provision
- All grades of clinical staff (including consultants) should be given mandatory training on the links between mental health and smoking and be trained on how to best provide tobacco dependence support to ensure patients receive the best possible care. Mental health trusts should focus on ensuring that all staff in direct contact with patients (such as nursing staff, community workers and doctors) consistently offer smoking advice and tobacco dependence support to every patient
- Each mental health setting should have clear prescribing pathways in place and varenicline and a range of NRT on the formulary
- Staff who smoke should be supported to access stop smoking services

## Substance misuse

Evidence rating: **C**

### Smoking and alcohol

The link between smoking and alcohol dependence is particularly strong,<sup>112</sup> with alcohol use disorders associated with regular, more dependent smoking.<sup>113</sup> Analysis of the most recent adult psychiatric morbidity survey highlights that alcohol dependence, which occurs in 6% of the adult population in England, is associated with a smoking prevalence of 46%.<sup>21</sup>

Stopping smoking does not seem to make it more difficult to stop drinking, although the evidence is not consistent and further research is required.

### Smoking and substance misuse

Daily smokers are more likely to have a co-morbid substance use disorder than people who have never smoked.<sup>114</sup> Smoking at an early age is also associated with substance misuse.<sup>115</sup> In addition, people who smoke tobacco are more likely to use cannabis and abuse alcohol. Using cannabis also makes smokers less likely to stop smoking tobacco.<sup>116</sup>

Analysis of the most recent adult psychiatric morbidity survey highlights that those suffering from drug dependence, which occurs in 3% of the adult population, have a smoking prevalence rate of 69%.<sup>21</sup> Recent evidence suggests that some smokers who use illicit drugs are less likely to quit as they perceive that this may have an adverse effect on their drug use, i.e. they think that they will need more of the illicit drug as a consequence of quitting.<sup>117</sup>

### Recommendations for stop smoking service providers

Stop smoking service providers will encounter clients with dual or multiple substance dependencies; these clients may find that continuation of substance use increases the risk of relapsing back to tobacco use.

### Key recommendations

- Ensure that staff in alcohol and drug services receive regular smoking cessation training<sup>u</sup>
- Develop links with alcohol and drug services to create referral pathways between these services and stop smoking services (VBA training should be considered)
- Ensure stop smoking practitioners are trained appropriately for the needs of the population attending the service so that they can deliver suitable information and advice on cannabis smoking and brief interventions concerning excessive alcohol use

## Prisoners

### Evidence rating: C

Whilst local authorities are not responsible for commissioning and delivering public health services for the criminal justice system, many areas do continue to provide stop smoking support in these settings.

It has been estimated that around 80% of the prison population smoke.<sup>32</sup> In 2012/13, 12,921 quit dates were set in a prisons with a self-reported four-week quit rate of 54%.<sup>13</sup>

There is not yet enough evidence to suggest what the best type of intervention for prison settings is. However, it would seem appropriate that interventions offered to the general population should be available to a group with such high levels of smoking and mental illness, and the basic quality principles remain the same irrespective of the intervention setting.

Embedding smoking cessation support across the criminal justice system (CJS) requires a wide range of stakeholders, providers and target groups to work together. Public Health England guidance on managing tobacco use and nicotine withdrawal in prisons is soon to be published and recommends that those involved in the CJS should:

- Raise the profile and priority of addressing smoking to ensure that all personnel working in the CJS are aware of the importance of cessation
- Work with offenders to understand their needs, promoting access to services delivered by trained practitioners and in line with NICE guidance
- Commit to on-going staff training in order that all prison staff are trained to provide very brief advice (VBA) (see page 43). Ensure that each setting has a range of staff trained to provide basic behavioural and pharmacological support and that prisoners wanting to quit have access to specialist stop smoking services
- Ensure NRT is available in settings where offenders are kept for short periods to help them manage nicotine withdrawal symptoms. Note: clear nicotine patches and mini lozenges should be available on every CJS site
- Ensure that all licensed stop smoking medications that are considered safe for use within the custodial environment are available on appropriate formularies

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<sup>u</sup> A free online training module in providing very brief advice on smoking is available at <http://elearning.ncsct.co.uk>

- Ensure, where clinically appropriate, that children and young people have access to NRT and behavioural support when they are required to stay in smokefree environments
- Ensure that all nicotine dependence treatment is delivered according to NICE standards
- Use existing electronic referral mechanisms to support the smoking cessation care pathway across the CJS on release or transfer to other prisons
- Stop smoking programmes should be integrated with treatment programmes for other conditions, such as substance misuse and mental health disorders

### Stop smoking interventions and Criminal Justice Settings

A pilot project undertaken by the UK Centre for Tobacco Control and Alcohol Studies examined the innovative role of a Regional Tobacco Coordinator (Criminal Justice System), which aimed to develop stop smoking support for offenders by working across criminal justice and relevant public health settings based on a systems approach. The pilot resulted in a number of recommendations, including:

- Recruitment of a coordinator is crucial in promoting a consistent, joined-up approach to enable multi-agency engagement with the tobacco control agenda across criminal justice settings (CJSs)
- A clear communication strategy should be developed with key players at a senior level across the system and disseminated through the networks as indicated by the coordinator
- Training should form an integral part of a consistent and joined-up approach across key organisations, coordinated at a central point, and include setting-specific brief intervention training for all staff
- Consistent structures should be established for integration into staff rotas, clinic room allocations, inmate appointments and prison movements to enhance engagement and be more manageable
- Ensuring sufficient staff are suitably trained to deliver stop smoking sessions
- Reviewing delivery approaches: one-to-one may be more suitable than group programmes, especially with high inmate turnover
- Ensuring sufficient nicotine replacement therapy is made available for quitters when transferred or released
- Ensuring that there are robust and consistent data collection and monitoring submissions, supported by electronic databases, particularly if services are delivered by prison-based staff
- Supporting the development of smokefree living areas and a wider health-promoting prison approach
- Providing brief intervention training across prison staff, with a setting-specific perspective, to raise awareness and support engagement

## Black and minority ethnic groups

### Evidence rating: **B**

Smoking prevalence varies greatly between ethnic groups and between men and women within these groups. Whilst smoking prevalence amongst minority ethnic groups is generally lower than that of the general population, some have higher rates, most notably amongst black Caribbean, Bangladeshi and Chinese men.

Prevalence data amongst minority ethnic groups is relatively limited, but the Race Equality Foundation's briefing *Tobacco use amongst minority ethnic populations and cessation interventions* does provide further information (see [www.better-health.org.uk/sites/default/files/briefings/downloads/health-brief22\\_0.pdf](http://www.better-health.org.uk/sites/default/files/briefings/downloads/health-brief22_0.pdf)).

About 14% of the UK population is from a black and minority ethnic group<sup>118</sup> and local stop smoking services generally recruit a larger proportion of clients from these groups. The number of smokers from ethnic minority groups accessing stop smoking services is summarised in Table 9.

**Table 9: Ethnic minority groups accessing stop smoking services 1st April 2013–31st March 2014**

Ethnic group	Number setting a quit date	Percentage of total number setting a quit date through services (n= 586,337)
White British	469,879	80.1
Any other white background	29,937	5.1
Not stated	26,291	4.5
Any other ethnic group	8,486	1.4
Pakistani	8,365	1.4
White Irish	6,521	1.1
Indian	6,508	1.1
Caribbean	5,583	1.0
African	4,365	0.7
Bangladeshi	4,101	0.7
White and black Caribbean	3,975	0.7
Any other Asian background	3,918	0.7
Any other mixed background	2,870	0.5
Any other black background	2,014	0.3
White and Asian	1,464	0.2
White and black African	1,244	0.2
Chinese	816	0.1

Areas with significant BME populations will need to carry out local mapping and joint needs assessments to inform the appropriate tailoring of local service promotion and delivery.

## Helpline support and resources

The NHS Smoking Helpline can provide expert advice on stopping smoking to South Asian tobacco users: 0800 022 4 332

**A guide to going smokefree is also available from the Smokefree Resource Centre in a range of languages** (see [http://resources.smokefree.nhs.uk/resources/results/?resource\\_type=Alternative+languages&resource\\_topics=&btn\\_Search.x=12&btn\\_Search.y=7](http://resources.smokefree.nhs.uk/resources/results/?resource_type=Alternative+languages&resource_topics=&btn_Search.x=12&btn_Search.y=7)).

## Niche tobacco products

The niche tobacco products covered in this section are waterpipes and smokeless tobacco.

### Prevalence of waterpipe tobacco use

Information on waterpipe use is not routinely collected in UK national health surveys, so data on prevalence is scarce. However, the UK has witnessed a 210% rise in the number of waterpipe cafes over the last five years.<sup>119</sup> Prevalence of waterpipe use amongst school pupils is reported to be 8%<sup>120</sup> and as high as 8–19% amongst university students.<sup>121–123</sup>

### User perceptions of harm

One particular concern regarding waterpipe tobacco smoking is the perception by users and non-users that it is safer than smoking.

A study amongst 242 General Practitioners (GPs) in the UK showed that only 57.1% felt that waterpipes were not a safe alternative to cigarette smoking.<sup>124</sup> This identifies a need for health education training amongst health and social care professionals as well as the general public.

### Prevalence of smokeless tobacco use

There are varying and contradictory estimates of the prevalence of smokeless tobacco use in English South Asian communities. The most comprehensive data is collected by the Health Survey for England (HSE), which reported a decrease in use in 2004 compared to an equivalent survey conducted in 1999,<sup>125</sup> although evidence for declining prevalence in smokeless tobacco use in the UK is not found in other sources.

Only two studies have validated self-reported smokeless tobacco use with salivary cotinine analyses. One reported a prevalence of 29%,<sup>122</sup> and the other 49.5%,<sup>126</sup> in a sample of Bangladeshi women. Thirteen other studies, focusing on Bangladeshi samples, reported prevalence estimates of between 2% and 57%.<sup>127</sup> It is accepted that Bangladeshi women are more likely chew tobacco than men.<sup>125</sup> There is no current evidence to support the proposition that these products are used within the general population.

The three main types of product that are available for purchase are zarda, gutkha and khaini. Other available products include tobacco leaf, toothpowder, mawa and qiwam.

Common ingredients in zarda, gutkha and khaini are tobacco flakes or powder and slaked lime (calcium hydroxide) as an alkalinity enhancer. Gutkha and zarda also include areca nut, a recognised carcinogen, and all three product types contain additional spices and flavourings such as saffron and menthol.

### Harms associated with niche tobacco product use

Both waterpipe and smokeless tobacco use have adverse effects on the cardiovascular system, such as increased blood pressure and heart rate. Niche tobacco products contain more than 30 carcinogens, including tobacco-specific nitrosamines.<sup>128</sup>

There is sufficient evidence to show that niche tobacco products may cause addiction, precancerous oral lesions and cancers of the oral cavity and the pancreas.<sup>129,130</sup> Specific niche tobaccos are also linked with oesophageal cancer and fatal ischaemic heart disease and stroke. As waterpipe tobacco is inhaled, it has also been associated with respiratory diseases such as chronic bronchitis and lung cancers, whereas inhaled second-hand waterpipe smoke has been implicated in the development of asthma in children.<sup>131</sup>

Nicotine dependence has been identified among niche tobacco users, specifically amongst those chewing paan with tobacco<sup>132</sup> and amongst regular waterpipe tobacco smokers.<sup>131</sup> Studies validating self-report measures of dependency with salivary cotinine scores found associations with a high daily consumption frequency, using within 30 minutes of waking and feelings of craving. A particular aspect of high dependency is the use of tobacco leaf and zarda together in the paan.<sup>133</sup>

### NICE guidance

NICE guidance PH39 (*Smokeless tobacco cessation: South Asian communities*) provides recommendations for supporting users of smokeless tobacco and can be accessed here: <http://publications.nice.org.uk/smokeless-tobacco-cessation-south-asian-communities-ph39#what-is-this-guidance-about>

### Other resources

The NCSCT has developed a briefing on waterpipe smoking (see [www.ncsct.co.uk/publication\\_waterpipe\\_tobacco\\_smoking.php](http://www.ncsct.co.uk/publication_waterpipe_tobacco_smoking.php)).

## Children and young people

### Evidence rating:

There is little published evidence about the effects of interventions that focus on cessation activity in adolescents both in school and in the wider community.<sup>134</sup> There is, however, evidence to show that supporting existing adult smokers to quit will help reduce the rate of smoking uptake.

In 2013/14 13,756 smokers under 18 years of age set a quit date with local stop smoking services, achieving a self-reported quit rate of 39% (5,405 quitters). Over two-thirds (68%) of all self-reported quits were CO validated compared to 70% in all ages.<sup>9</sup>

Despite the lack of evidence, services should be available for young people who want to stop smoking, and local stop smoking service providers should link with other programmes to ensure they reach as many children and young people as possible (e.g. through healthy school programmes, and health services on secondary school sites and in other youth settings).

## Relapse prevention

**Evidence rating:** 

There is currently little evidence suggesting which behavioural interventions are most likely to prevent people partially or totally resuming smoking. However, extended use of varenicline may be helpful, and further research is required to ascertain the benefits of prolonged behavioural support and extended use of NRT<sup>135</sup> (see Annex I).

## 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 very brief advice on how to stop smoking (see page 43). As the majority of successful quit attempts are unplanned or spontaneous, smokers should also be enabled to stop whenever they want to (see Treatment episode, page 92).<sup>136</sup>

Quit attempts should draw on experiences from previous attempts to stop and should bear in mind factors that contributed to previous relapses (i.e. high nicotine dependence). 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 support.

# PART 3: MONITORING LOCAL STOP SMOKING SERVICES

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## 1. National monitoring

Stop smoking service activity data has been captured nationally since 1999; previously published data can be accessed via the Health and Social Care Information Centre (HSCIC).<sup>v</sup>

The purpose of the national data set is to help monitor and evaluate the effectiveness and reach of stop smoking services. It is designed to provide consistent information on people who have sought and received quitting help from an evidence-based service.

**The national data set 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 practitioners, as detailed in the definitions (based on the Russell Standard (Clinical) and available in Annex B).**

This routine data collection has been invaluable in supporting the national tracking of the services' success and has frequently informed further research into smoking cessation. It has also helped local areas benchmark their activity and, through the process of data submission, identify providers who may require additional support.

Since 1st April 2013, the data collection became a voluntary, rather than mandatory, requirement. To maintain the integrity of the collection it is vital that areas continue to provide their data and, encouragingly, it seems that the majority of areas are continuing to do so.

A number of changes were made to the collection in 2014 that came into effect from 1st April of that year.<sup>w</sup> These changes included:

- Revised data requirements regarding the use of licensed and unlicensed nicotine containing products (e.g. nicotine vapourisers) by those using services
- Revised intervention settings
- Clarification regarding eligibility for free prescriptions
- Restructured financial information section

Local areas are, however, encouraged to undertake greater monitoring of activity (see Measuring success, page 36).

### Recording of sexual orientation

Currently, sexual orientation data is not captured as part of the national stop smoking service data collection. However, higher than average smoking prevalence and health inequalities are evident amongst the lesbian, gay, bisexual and transgender (LGBT) communities; as such there is an increasing focus on ensuring that services are engaging and meeting the health needs of this population. Therefore local areas need to consider how they are measuring such activity as part of standard local monitoring.

v [www.hscic.gov.uk/searchcatalogue?topics=2%2fPublic+health%2fLifestyle%2fSmoking&sort=Relevance&size=10&page=1#top](http://www.hscic.gov.uk/searchcatalogue?topics=2%2fPublic+health%2fLifestyle%2fSmoking&sort=Relevance&size=10&page=1#top)

w For a summary of these changes see: [www.ncsct.co.uk/usr/pub/Changes\\_to\\_LSSS\\_data.pdf](http://www.ncsct.co.uk/usr/pub/Changes_to_LSSS_data.pdf)

Due to the sensitive nature of this data, it is recommended that clients are shown a list of options and asked to select the number that they feel best describes how they think about their sexuality. This number is then recorded on the standard monitoring system. Where this interaction is carried out over the phone, it is customary to read out the list without pausing between the options and asking the client to select the number of the description that they feel is most accurate once all of the options have been given. The Integrated Household Survey includes the following tested options and question wording:

***“Which of the options on this card best describes how you think of yourself?  
Please just read out the number next to the description.”***

Or, if discussing over the phone:

***“I will now read out a list of terms people sometimes use to describe how they think of themselves. Please select the option, from one to five, that best describes how you think of yourself.”***

Read list to end, including the numbers, without pausing.

1. Heterosexual or Straight
2. Gay or Lesbian
3. Bisexual
4. Other
5. Prefer not to disclose

## 2. Definitions and data quality

In order to improve the consistency and usefulness of the data collection and subsequent publications, it is important that all stop smoking services adopt strict criteria when deciding who to include in their monitoring return and the four-week quit status of clients. These criteria need to be applied consistently; clear definitions are provided in Annex B.

## 3. Submitting data to the HSCIC

Data is captured at the end of each quarter, starting with quarter 1, which runs from 1st April to 30th June. Details of the collection can be found here: [www.hscic.gov.uk/stopsmoking](http://www.hscic.gov.uk/stopsmoking).

At the end of the monitoring period (one quarter plus six weeks), local areas have a further four weeks to submit data to the HSCIC 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, there is a total of 10 weeks to submit returns for quarters 1, 2 and 3 and 11 weeks to return 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**. 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 HSCIC produces three sets of tables at local, regional and national levels, accompanied by a summary describing the key results. Within the quarter 4 annual report all provisional figures from previous quarters are confirmed and figures are deemed final.

**Table 10: 2014–15 returns timetable**

Quarter	End of 6 week follow-up period	Deadline to submit data to HSCIC and elapsed weeks	Date of publication by HSCIC website
1. April to June	12.08.14	09.09.14	29.10.14
2. July to September	13.11.14	09.12.14	15.01.15
3. October to December	13.02.15	13.03.15	23.04.15
4. January to March	13.05.15	16.06.15	19.08.15

## Capturing monitoring information

A template monitoring form to encourage greater consistency in the collection of the minimum national data set has been included in previous versions of this guidance, and again in this document (Annex G); an electronic version of the form is available at [www.ncsct.co.uk/publication\\_standard\\_monitoring\\_form%20.php](http://www.ncsct.co.uk/publication_standard_monitoring_form%20.php)

However, this standard monitoring form has been adapted by some local areas to include further information that would generally be captured as part of the treatment programme. An example of a more comprehensive treatment and monitoring form has thus been developed (Annex H) and an electronic version of the form is available at [www.ncsct.co.uk/publication\\_ncsct-stop-smoking-service-client-record-form.php](http://www.ncsct.co.uk/publication_ncsct-stop-smoking-service-client-record-form.php)

Some areas have invested in web-based information systems to help streamline their data collection and to analyse service performance. Such systems are of great benefit to commissioners and have proved a highly worthwhile investment in a number of areas. It is important that commissioners have access to anonymised provider data to inform current and future commissioning, and access to data should be agreed as part of the contractual process.

To facilitate service audits and comply with clinical governance, all service providers should maintain adequate client records (to include all client contacts, medications used and smoking status). It is also important that service providers return data on all clients treated (not just on successful outcomes) so that success rates may be accurately calculated.

It is further recommended that service providers or practitioners that repeatedly submit incorrect or incomplete data receive refresher training in the approved definitions and procedures. Any data that they submit should be subject to regular spot checks until the service lead is satisfied that the correct procedures and definitions are being used.

## Exception reporting

Before submitting quarterly data, it is recommended that service leads and/or commissioners examine the data so that, if they find outlying data, they can carry out an exception reporting procedure.

For example, self-reported four-week quit rates would be expected to be between 35% and 70%. If the overall results from a provider (or those for a specific intervention type/setting) fall outside this range then an area may wish to conduct further checks.

The procedure outlined below is the exception reporting process previously recommended, and it is offered here as an example:

**Step 1: The service provider or practitioner is contacted and asked to confirm that all the standard data definitions (see Annex B) 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.

**Step 2: If the service provider or practitioner asserts that the approved definitions have been used, random checks of 10% of smokers treated by the service provider concerned should be carried out by telephone (or face to face if possible).**

This should establish whether the patient/client meet the criteria for self-reported or CO-verified four-week quits and whether they have received an approved intervention of the required content and duration.

If the random checks indicate that recorded quits are unreliable, all cases received from this provider may then need to 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, a further review into the causes may be required.

## 4. Reviewing service provision

In addition to exception reporting, it is recommended that services have quality assurance procedures in place to ensure the quality of the service being provided, which should include an element of independent auditing to complement internal checks. Minimum quality assurance requirements should be clear in service specifications and service provider contracts and form part of the service quality performance reports.

Client satisfaction is a useful quality assurance measure. A tested client satisfaction survey can be found here: [www.ncsct.co.uk/usr/pub/Client%20satisfaction%20questionnaire.pdf](http://www.ncsct.co.uk/usr/pub/Client%20satisfaction%20questionnaire.pdf).

## Annex A: Checklist for commissioners

### Procuring services (if going out to tender)

Recommendation	Action required	Expected date of completion
Have you contacted your procurement team for advice and support about the local procurement process?		
Do you have access to internal and external tobacco control networks for advice and support from peers?		
Do you know if the local authority policy is to carry out a single or two-stage procurement process?		
Has the legal team been engaged at an early stage to agree the terms and conditions?		
Will it be possible to hold a bidders event prior to the issuing of the tender documentation?		

The following headings are taken from the latest service specification template (contained within the public health services' non-mandatory contract template) available at: [www.gov.uk/government/publications/public-health-services-non-mandatory-contracts-and-guidance-published](http://www.gov.uk/government/publications/public-health-services-non-mandatory-contracts-and-guidance-published).

<b>Population needs</b>		
<b>Recommendation</b>	<b>Action required</b>	<b>Expected date of completion</b>
Have you established the composition of your local smoking population and its service needs?		
Have you obtained local prevalence and current activity data on smoking populations?		
Is the scope (service configuration) informed by local intelligence, community engagement and customer evaluation involving different populations?		
Have services been weighted in terms of deprivation and does this include high-risk groups such as pregnant women, prisoners or smokers with mental health diagnoses?		
Is the service model clear (e.g. are single or multiple providers being commissioned?)		
<b>Key Service Outcomes</b>		
<b>Recommendation</b>	<b>Action required</b>	<b>Expected date of completion</b>
Are these measurable and will you have access to the data in order to measure them?		
How do the overarching outcomes fit with the Quality Outcomes Indicators (Appendix C of the contract)?		

<b>Scope</b> <b>Are the following clear within the service specification scope:</b>	✓ / ✗
Aims of the service	
Key objectives of the service	
Service description / model	
Who is responsible for the development of referral pathways and engaging with local networks to increase the delivery of very brief advice (including any training requirements)?	
Who is responsible for marketing and communications?	
Any other responsibilities as applicable including supporting / managing other providers?	
Any specific geographical or hours of operations requirements (if not being left to the provider to decide)?	
Who is eligible to access the service and are there any exclusion criteria?	
The need for interventions to be evidence-based and to adhere to the intervention principles (within this 2014 service and monitoring guidance)?	
The need for support sessions to be delivered in clean and private premises?	
The need for clients to be contacted as soon as a referral is received (or at least within two working days) and for an appointment to be offered within one week?	
The need for interventions to be delivered by NCSCT certified practitioners who have also received face-to-face training (that meets the published NCSCT national training standards) and who receive update training at least annually?	
The need for multi-sessional, weekly interventions and minimum client contact time (dependent on 1:1 or group support)?	
That all licensed pharmacotherapy, including combination therapy, should be available as first-line treatment options?	
That clients wishing to use an unlicensed product (such as nicotine vapourisers) to stop can receive behavioural support from the service?	
Whether clients who are not smoking but who wish to stop using long-term NRT or unlicensed products (such as nicotine vapourisers) can receive support from the service?	
The importance of CO validating smoking status (in at least 85% of clients)?	

<b>Quality Outcomes Indicators (Appendix C)</b>		
<b>Recommendation</b>	<b>Action required</b>	<b>Expected date of completion</b>
Are these measurable and will they help monitor progress towards the 'Key Service Outcomes'?		
Are quit outcomes based upon the Russell Standard and are these definitions clear?		
How will you verify the outcomes reported?		
Will you have access to all unidentifiable data?		
Are providers required to undergo an independent review as well as conducting internal quality assurance checks? (links to Appendix J in the contract template)?		
Is it clear what the consequences will be if the provider does not achieve the outcome?		
Do these include client satisfaction indicators (links to Appendix D in the contract template)?		



<b>Charges (Appendix E)</b> <b>Have the following been taken into account, as appropriate, when calculating the budget / outcome payments:</b> (Note: this is not intended to be an exhaustive list, but simply highlights some of the key points raised within this guidance document.)	✓ / X
Marketing and service promotion?	
Staff costs including adequate management and administration support?	
TUPE requirements?	
IT and telecoms maintenance?	
Supply and maintenance of CO monitors, adaptors, mouthpieces, calibration kits, etc.?	
Office base / equipment?	
Training?	
Provision of pharmacotherapy?	
Service review / auditing?	
Sundries, e.g. stationary, postage?	
Will any bonus payments apply?	

## Annex B: Definitions

### CO-verified four-week quitter

A treated smoker who reports not smoking for at least days 15–28 of a quit attempt and whose CO reading is assessed 28 days from their quit date (–3 or +14 days) and is less than 10 ppm. 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 time span may not be counted for the purposes of quarterly data submissions to the HSCIC. CO verification should be conducted face to face and carried out in at least 85% of self-reported four-week quitters.**

### Lost to follow-up (LTFU)

A treated smoker who cannot be contacted face to face, via telephone, email, letter or text following three attempts to contact them at different times of day, at four weeks from their quit date (or within 25 to 42 days of the quit date). The four-week outcome for this client is unknown and should therefore be recorded as LTFU on the monitoring form.

### Stop smoking service provider

A stop smoking service provider is defined as a locally managed and coordinated service commissioned to provide accessible, evidence-based and 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 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 health fairs or community events, during a GP consultation or during a hospital stay where a quit date is not set and a quit attempt is not made.

### Quit date

The date a smoker plans to stop smoking completely with support from a stop smoking practitioner as part of an assisted quit attempt.

### Renewed quit attempts

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 of a routine and manual (R/M) worker as defined by the National Statistics Socio-Economic Classification.<sup>137</sup>

### Self-reported four-week quitter

A treated smoker who reports not smoking for at least days 15–28 of a quit attempt and is followed up 28 days from their quit date (–3 or +14 days).

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).

### Smoked product

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

### 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 this is 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 can only be counted as having been ‘treated’ and included in the national data return if they had quit 48 hours or less before attending the first session of a structured multi-session treatment plan. Where this is the case, their spontaneous quit date should be recorded as their actual quit date.

Examples of such quitters include clients who experience unplanned admission to hospital and stop smoking before receiving support, those people who have started using nicotine vapourisers (as an alternative to smoking) and have not smoked for up to 48 hours, or pregnant smokers who have already stopped smoking before approaching their local stop smoking service provider. Whilst 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.

Smokers who have already stopped smoking for more than 48 hours before attending a service should not be included in the national data submission but may be counted as having been ‘treated’ for local accounting purposes (e.g. to justify resources used or analyse performance). It is recommended that this is only recorded if they have quit within 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 their quit date).

### Stop smoking

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

### **Stop smoking practitioner**

An individual who has NCSCT certification and is employed by a service which is, either directly or indirectly, commissioned to provide stop smoking support.

### **Time between treatment episodes**

(see Treatment episode, below)

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 practitioner should use discretion and 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 practitioner in order to be counted as a new data entry on the quarterly return.

### **Treated smoker**

A smoker who has received at least one session of a structured, multi-session intervention (delivered by a stop smoking practitioner) on or prior to the quit date, who consents to treatment and sets a quit date with a stop smoking practitioner. 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 practitioner, a client becomes a treated smoker and the treatment episode begins. The treatment episode ends when a client has been completely abstinent for at least the two weeks prior to the four-week follow-up 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.

## Annex C: NICE guidance

### National Institute for Health and Clinical Excellence

The National Institute for Health and Clinical Excellence (NICE) is an independent organisation responsible for providing national guidance and standards on improving health and treating ill health. As part of this core remit, NICE produces public health guidance on the promotion of good health and the prevention of ill health for those working in the NHS, local authorities and the wider public and voluntary sectors. More information is available at [www.nice.org.uk/guidance/phg/index.jsp](http://www.nice.org.uk/guidance/phg/index.jsp)

All of the following NICE guidance is directly related to smoking cessation and tobacco control and can be accessed from the NICE website. Each piece of guidance is informed by reviews of evidence of effectiveness and cost-effectiveness, and is drawn up by clinical, academic and policy experts in the field. The evidence reviews can also be found on the NICE website under the relevant piece of guidance.

### Public health guidance

- Brief interventions and referral for smoking cessation (PH1)
- Workplace interventions to support smoking cessation (PH5)
- Smoking cessation services (PH10)
- Preventing the uptake of smoking by children and young people (PH14)
- Identifying and supporting people most at risk of dying prematurely (PH15)
- School-based interventions to prevent smoking (PH23)
- Quitting smoking in pregnancy and following childbirth (PH26)
- Smokeless tobacco cessation (PH39)
- Tobacco harm reduction (PH45)
- Smoking cessation: acute, maternity and mental health services (PH48)

### Quality standards

- Smoking cessation: supporting people to stop smoking (QS43)

### Technical appraisals

- Smoking cessation: varenicline (TA123)
- Smoking cessation: bupropion and nicotine replacement therapy (TA39, replaced by PH10)

## **Annex D:** The Smokefree Resource Centre

To help support local marketing, a toolkit of creative resources is now available, along with Smokefree literature, brand materials (including font, photographs and logo) and additional guidance, from the Smokefree Resource Centre (see [www.smokefree.nhs.uk/resources](http://www.smokefree.nhs.uk/resources)).

This includes a suite of branded artwork templates for leaflets, posters and other marketing materials that can be used to help promote local services (NHS and non-NHS providers alike). The templates are editable PDFs, which can be tailored for local use simply by adapting the logo and contact details, or by replacing sections with relevant local information.

The Smokefree Resource Centre also has the latest news about the national campaign and resources available, case studies and a range of guides that can be used to carry out local marketing activity. Materials to help support local marketing and engagement with partners can also be ordered or downloaded from the centre.

## Annex E: Further useful resources

<a href="http://www.nhs.uk/smokefree">www.nhs.uk/smokefree</a>	<b>Smokefree campaign:</b> with information, tools and video content for smokers who want to be smokefree. Smokers can also look up their local stop smoking service provider
<a href="http://www.ncsct.co.uk">www.ncsct.co.uk</a>	<b>National Centre for Smoking Cessation and Training (NCSCT):</b> register and access for free online training, keep up to date with latest developments from the centre and access a range of smoking cessation related resources
<a href="http://www.hscic.gov.uk">www.hscic.gov.uk</a>	<b>Health &amp; Social Care Information Centre (HSCIC):</b> access a wide range of data including national stop smoking service statistics
<a href="http://www.tobaccoprofiles.info">www.tobaccoprofiles.info</a>	<b>Local Tobacco Control Profiles for England:</b> provides a snapshot of the extent of tobacco use, tobacco-related harm and measures being taken to reduce this harm at a local level
<a href="http://www.nice.org.uk">www.nice.org.uk</a>	<b>National Institute of Health and Care Excellence (NICE):</b> access national guidance and standards on improving health and treating ill health
<a href="http://emc.medicines.org.uk">http://emc.medicines.org.uk</a>	<b>Electronic Medicines Compendium:</b> access the summary of product characteristics (SPCs) for all medications
<a href="http://www.ash.org.uk">www.ash.org.uk</a>	<b>Action on Smoking and Health (ASH):</b> a campaigning public health charity that works to eliminate the harm caused by tobacco. Access a range of resources and publications and sign up to a daily news update
<a href="http://www.smokefreeaction.org.uk">www.smokefreeaction.org.uk</a>	<b>Smokefree Action Coalition (SFAC):</b> a group of organisations committed to promoting public health, which came together initially to lobby for smokefree workplaces and is now committed to reducing the harm caused by tobacco more generally
<a href="http://www.uknsc.org">www.uknsc.org</a>	<b>UK National Smoking Cessation Conference (UKNSCC):</b> keep up to date with future conferences and access presentations from previous events
<a href="http://www.mhra.gov.uk/index.htm">www.mhra.gov.uk/index.htm</a>	<b>Medicines and Healthcare products Regulatory Agency (MHRA):</b> responsible for regulating all medicines and medical devices in the UK by ensuring they work and are acceptably safe
<a href="http://www.cochrane.org/reviews">www.cochrane.org/reviews</a>	<b>Cochrane reviews:</b> access systematic reviews of research evidence

## Annex F: Evaluation pro forma

### Service information

Name of stop smoking provider	
Name and contact details of the work / project lead	
Key characteristics of the population within the area served by the service	

### Project outline

Target audience for the intervention	
Rationale for developing the intervention	
Evidence used to support the rationale	
Aims of the work	
Objectives of the work	
Processes and timelines	
Methods used	



**Outcomes (examples given below)**

Number of leads generated:	
Cost per lead generated:	
Number of quit dates set (QDS):	
Cost per QDS:	
Number of XX week quits:	
Cost per XX week quit:	

**Costs**

<b>Item</b>	<b>Cost (£)</b>
Staffing	
Medication (please specify): NRT Varenicline Bupropion Access to medication costs:	
Marketing	
Overheads (please specify):	
Premises	
Travel	
Other (please specify):	
Total:	

**Pre- and post-implementation data**

<b>Timescales</b>	<b>1 month 4-week quits</b>	<b>6 month 4-week quits</b>	<b>12 month 4-week quits</b>
Pre-implementation			
Post-implementation			

## Annex G: Standard monitoring form

# STANDARD MONITORING FORM

(INSERT SERVICE NAME & ADDRESS) STOP SMOKING SERVICE

Note: All patient data will be kept securely and in accordance with Caldicott guidelines.

PRACTITIONER DETAILS	
Practitioner Name	Venue
Contact tel. no.	Practitioner code/ref

CLIENT DETAILS		
Surname		
First name	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> other (please specify)	
Address		
Postcode	NHS ID no.	
Daytime tel. no.	Mobile no.	
Alternative contact number (friend/relative)		
Date of birth	Age (in years)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Exempt from prescription charge – record here only those able to prove that they are eligible to receive free prescriptions <input type="checkbox"/> Yes <input type="checkbox"/> No		
Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No	Breastfeeding <input type="checkbox"/> Yes <input type="checkbox"/> No	
Occupation code (see notes on page 3 for further information)		
<input type="checkbox"/> Full-time student	<input type="checkbox"/> Never worked/unemployed over a year	<input type="checkbox"/> Retired
<input type="checkbox"/> Home carer (unpaid)	<input type="checkbox"/> Sick/disabled and unable to work	<input type="checkbox"/> Managerial/professional
<input type="checkbox"/> Intermediate	<input type="checkbox"/> Routine manual	<input type="checkbox"/> Prisoner
<input type="checkbox"/> Unable to code		
Sexual orientation (insert number 1–5. See notes on page 3 for further information)		

ETHNIC GROUP (please tick relevant group)		
<b>a. White</b> <input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> Other white background	<b>b. Mixed</b> <input type="checkbox"/> White and Black Caribbean <input type="checkbox"/> White and Black African <input type="checkbox"/> White and Asian <input type="checkbox"/> Any other mixed background	<b>c. Asian or Asian British</b> <input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Other Asian background
<b>d. Black or Black British</b> <input type="checkbox"/> Caribbean <input type="checkbox"/> African <input type="checkbox"/> Other Black background	<b>e. Other ethnic groups</b> <input type="checkbox"/> Chinese <input type="checkbox"/> Other ethnic group	<b>f. Not stated</b> <input type="checkbox"/> Not stated

HOW CLIENT HEARD ABOUT THE SERVICE (please tick relevant box)			
<input type="checkbox"/> GP	<input type="checkbox"/> Friend/relative	<input type="checkbox"/> Pharmacy	<input type="checkbox"/> Other health professional
<input type="checkbox"/> Advertising		<input type="checkbox"/> Other (please specify)	

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

Continued overleaf >>

INTERVENTION SETTING		
<input type="checkbox"/> Community setting	<input type="checkbox"/> Dental setting	<input type="checkbox"/> Prison setting
<input type="checkbox"/> Community psychiatric setting	<input type="checkbox"/> General practice setting	<input type="checkbox"/> Military base setting
<input type="checkbox"/> Hospital setting	<input type="checkbox"/> Maternity setting	<input type="checkbox"/> Workplace setting
<input type="checkbox"/> Psychiatric hospital setting	<input type="checkbox"/> Children's centre setting	<input type="checkbox"/> Other setting (please describe)
<input type="checkbox"/> Pharmacy setting	<input type="checkbox"/> Education setting	

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		
<input type="checkbox"/> Closed group	<input type="checkbox"/> Telephone support	<input type="checkbox"/> Open (rolling) group
<input type="checkbox"/> Couple/family	<input type="checkbox"/> One-to-one support	<input type="checkbox"/> Drop-in clinic
<input type="checkbox"/> Other (please specify)		

TYPE OF LICENSED PHARMACOLOGICAL SUPPORT USED (please tick all relevant boxes)		
<input type="checkbox"/> Single NRT	<input type="checkbox"/> Combination NRT	<input type="checkbox"/> Champix
<input type="checkbox"/> Zyban	<input type="checkbox"/> None	<input type="checkbox"/> Licensed NRT plus Zyban / Champix
<b>Where more than one pharmacotherapy has been used were these:</b>		
<input type="checkbox"/> Used at the same time		
<input type="checkbox"/> Used consecutively (i.e. the client switched use as part of a single quit attempt but not used at the same time)		
<b>NRT products used</b> (only complete if the client used either single or combination NRT)		
<input type="checkbox"/> Patch	<input type="checkbox"/> Gum	<input type="checkbox"/> Lozenge
<input type="checkbox"/> Nasal spray	<input type="checkbox"/> Mouth spray	<input type="checkbox"/> Oral strips
<input type="checkbox"/> Inhalator	<input type="checkbox"/> Microtab	

USE OF UNLICENSED NICOTINE CONTAINING PRODUCT (NCP)
Unlicensed NCP (e.g. unlicensed e-cigarette) used: <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If yes was this:</b>
<input type="checkbox"/> Used instead of licensed medication
<input type="checkbox"/> Used at the same time as licensed medication
<input type="checkbox"/> Used consecutively to licensed medication (i.e. the client switched use as part of a single quit attempt but not used at the same time)

TREATMENT OUTCOME
<input type="checkbox"/> Not quit <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Quit self-reported <input type="checkbox"/> Quit CO verified

Practitioner signature

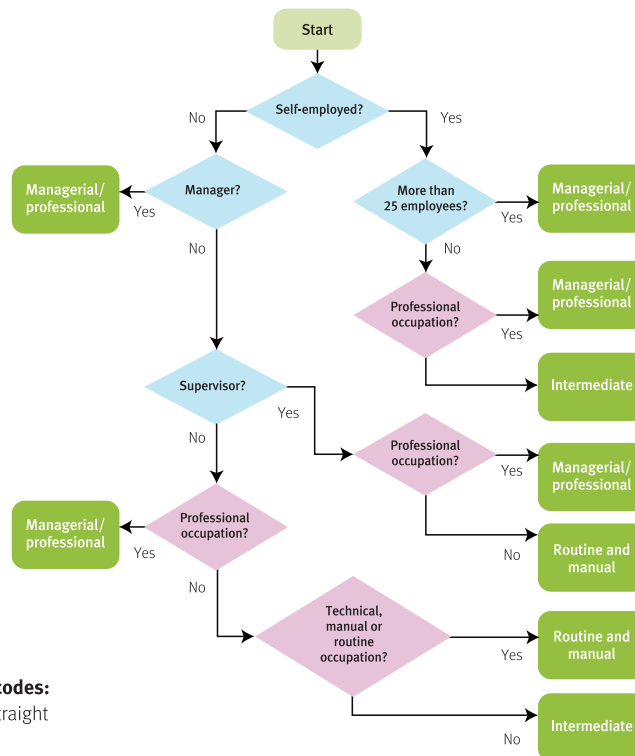
Client signature

Signing this form indicates consent to treatment and the sharing of outcome data with your GP and/or referrer. Data may also be used for follow-up and service review purposes including by a third party where applicable.

## Notes

1. Location/setting should be one of the following: stop smoking services, pharmacy, prison, primary care, hospital ward, dental practice, military base setting or other.
2. 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.
3. Home carer – i.e. looking after children, family or home.
4. If a client is self-employed please use the flowchart below to determine classification.
5. Supervisor or Foreman is responsible for overseeing the work of other employees on a day-to-day basis.
6. Managerial and professional occupations 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 or finance.
7. Intermediate occupations include: call centre agent, clerical worker, nursing auxiliary, nursery nurse, office clerk, secretary.
8. Routine and manual occupations 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.
9. The 'prisoner' occupation category has been introduced for collections from 2009/10 onwards in an effort to reduce the number of clients recorded under 'unable to code.' With the exception of prison staff, clients treated in prisons should all be recorded as prisoners.

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



### Sexual orientation codes:

1. Heterosexual or Straight
2. Gay or Lesbian
3. Bisexual
4. Other
5. Prefer not to disclose

## Annex H: Client record form

### Stop Smoking Service Client Record Form

1

Name of Stop Smoking Service

Practitioner name

Service advisor no.

Venue

Contact tel

Intervention setting

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Community setting               | <input type="checkbox"/> Dental setting            | <input type="checkbox"/> Education setting     |
| <input type="checkbox"/> Community psychiatric setting   | <input type="checkbox"/> General practice setting  | <input type="checkbox"/> Prison setting        |
| <input type="checkbox"/> Hospital setting                | <input type="checkbox"/> Maternity setting         | <input type="checkbox"/> Military base setting |
| <input type="checkbox"/> Psychiatric hospital setting    | <input type="checkbox"/> Children's centre setting | <input type="checkbox"/> Workplace setting     |
| <input type="checkbox"/> Pharmacy setting                |  |  |
| <input type="checkbox"/> Other setting (please describe) |  |  |

Intervention type

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Closed group           | <input type="checkbox"/> Telephone support  | <input type="checkbox"/> Open (rolling) group |
| <input type="checkbox"/> Couple / family        | <input type="checkbox"/> One-to-one support | <input type="checkbox"/> Drop-in clinic       |
| <input type="checkbox"/> Other (please specify) |   |   |

Client surname

Mr  Mrs  Ms  Other (please specify)

Client first name

Address

Postcode

GP details

Tel / Mobile

Alternative tel

Email

Date of birth

Age

Gender  Male  Female

Pregnant  Yes  No

Breastfeeding  Yes  No

Exempt from prescription charge  Yes  No

Record here only those are able to prove that they are eligible to receive free prescriptions

Occupation code (see guide on page 5)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Full-time student   | <input type="checkbox"/> Never worked / unemployed over a year | <input type="checkbox"/> Retired                   |
| <input type="checkbox"/> Home carer (unpaid) | <input type="checkbox"/> Sick / disabled and unable to work    | <input type="checkbox"/> Managerial / professional |
| <input type="checkbox"/> Intermediate        | <input type="checkbox"/> Routine and manual                    | <input type="checkbox"/> Prisoner                  |
| <input type="checkbox"/> Unable to code      |  |  |

Sexual orientation (insert number 1–5. See notes on page 5 for further information)

## Stop Smoking Service Client Record Form

2

<b>Ethnic group</b>	<b>White</b> <input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> Other White background  <b>Black or Black British</b> <input type="checkbox"/> African <input type="checkbox"/> Caribbean <input type="checkbox"/> Other Black background	<b>Mixed</b> <input type="checkbox"/> White and Black Caribbean <input type="checkbox"/> White and Black African <input type="checkbox"/> White and Asian <input type="checkbox"/> Other mixed background  <b>Other ethnic groups</b> <input type="checkbox"/> Chinese <input type="checkbox"/> Other ethnic group	<b>Asian or Asian British</b> <input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Other Asian background  <b>Other</b> <input type="checkbox"/> Not stated
---------------------	---	--	--

### How client heard about the service

GP  
  Other health professional  
  Friend / relative  
  Advertising  
  Pharmacy  
  Other

Agreed quit date

Expected date of last tobacco use

Expected date of 4-week follow up

Date of 12-week follow up

### Type of licensed pharmacological support used (please tick all relevant boxes)

Single NRT  
  Combination NRT  
  Champix  
  Zyban  
  Licensed NRT plus Zyban/Champix  
  None

### Where more than one pharmacotherapy has been used were these:

Used at the same time  
 Used consecutively (i.e. the client switched use as part of a single quit attempt but not used at the same time)

### NRT products used (only complete if the client used either single or combination NRT)

Patch  
  Gum  
  Lozenge  
  Nasal spray  
  Mouth spray  
  Oral strips  
  Inhalator  
  Microtab

### Use of unlicensed nicotine containing product (NCP)

Unlicensed NCP (e.g. unlicensed e-cigarette) used  Yes  No

### If yes was this:

Used instead of licensed medication  
 Used at the same time as licensed medication  
 Used consecutively to licensed medication (i.e. the client switched use as part of a single quit attempt but not used at the same time)

Time to first cigarette of the day  over 60 min  31 to 60 min  6 to 30 min  within 5 min

Usual daily cigarette consumption \_\_\_\_\_ cigarettes per day

Practitioner signature

Client signature

Signing this form indicates consent to treatment and the sharing of outcome data with your GP and/or referrer. Data may also be used for follow-up and service review purposes including by a third party where applicable.

## Stop Smoking Service Client Record Form

3

### Further measures at first assessment visit

How much of the time is currently spent with urges to smoke?

None of the time     A little of the time     Some of the time     A lot of the time     Almost all of the time

How strong are the urges?

No urges     Slight     Moderate     Strong     Extremely strong

Time since most recent quit attempt

How long most recent quit attempt lasted

Currently being treated for physical health problems     Yes     No

Currently being treated for drug or alcohol problems     Yes     No

Currently being treated for other mental health problems     Yes     No

Currently using any medications     Yes     No

Further details

Partner smoking status     Does not smoke / not applicable     Smokes

Current cannabis use     Yes     No

Alcohol consumption     Up to 14 units per week     15 to 21 units per week     More than 21 units per week

Past experience of stop smoking medicines (Please tick all that apply)

NRT     Zyban (bupropion)     Champix (varenicline)     Other

### Outcome

4-week quit    Self-report of not a puff in past 2 weeks (days 15 – 28)     Yes     No     Not known

CO reading

CO-verified 4-week quitter     Yes     No

12-week quit    Self-report of not a puff in past 10 weeks     Yes     No     Not known

CO reading

CO-verified 12-week quitter     Yes     No



**Stop Smoking Service Client Record Form**

4

**Clinical notes** (describe any concurrent medication, medication side effects, withdrawal symptoms, barriers to abstinence and other relevant information)

**Session 1: Pre-quit**CO reading **Session 2: Quit date**CO reading **Session 3: Post-quit week 1**CO reading **Session 4: Post-quit week 2**CO reading **Session 5: Post-quit week 3**CO reading **Session 6: Post-quit week 4**CO reading **Additional sessions**

## Stop Smoking Service Client Record Form

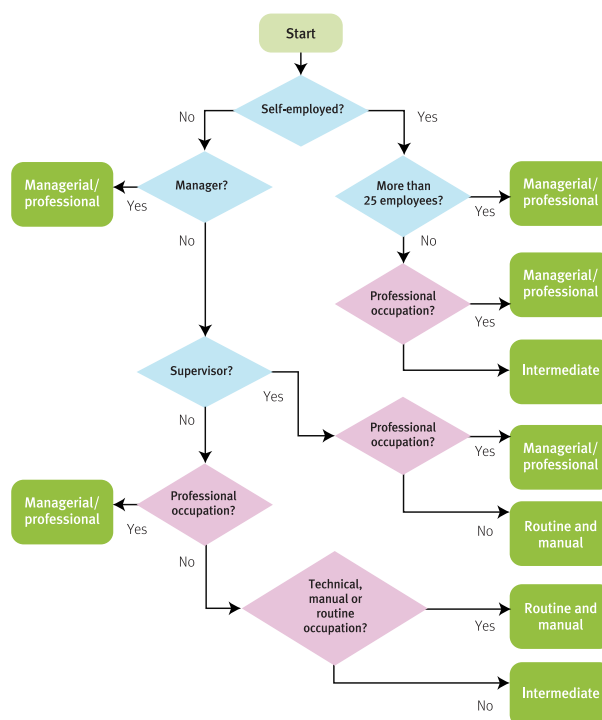
5

### How to code occupational group

Occupation Code	Note
<b>Full-time student</b>	
<b>Home carer</b>	Home carer – i.e. looking after children, family or home.
<b>Retired</b>	
<b>Never worked / long-term unemployed</b>	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.
<b>Sick / disabled and unable to work</b>	
<b>Managerial / professional</b>	Managerial and professional occupations 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, organizing, and co-ordinating work or finance; self-employed professionals (occupations listed as above) or self-employed and employing more than 25 people.
<b>Intermediate</b>	Intermediate occupations include: call centre agent, clerical worker, nursing auxiliary, nursery nurse, office clerk, secretary; non-professional self-employed individuals, or self-employed and employing less than 25 people.
<b>Routine manual</b>	Routine and manual occupations 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.
<b>Prisoner</b>	The 'prisoner' occupation category has been introduced for collections from 2009/10 onwards in an effort to reduce the number of clients recorded under 'unable to code'. With the exception of prison staff, clients treated in prisons should all be recorded as prisoners.
<b>Unable to code</b>	

#### Sexual orientation codes:

1. Heterosexual or Straight
2. Gay or Lesbian
3. Bisexual
4. Other
5. Prefer not to disclose



## Annex I: Harm reduction

Guidance on tobacco harm reduction was published by NICE in June 2013.<sup>138</sup> The guidance clearly states that smokers should still be advised that stopping smoking abruptly using existing evidence-based interventions provides the best chance of successful long-term abstinence from smoking. The guidance also states that investment in harm reduction activity should not detract from the funding of existing stop smoking services.

This NICE guidance is aimed at engaging with people who do not want to, or cannot, quit in one step, many of whom will choose not to use stop smoking services. For these smokers, other options are described in the guidance, such as self-help that may fall outside the remit of stop smoking services. Four approaches feature:

### 1. Stopping smoking:

- using one or more licensed nicotine containing products for as long as is needed to prevent relapse

### 2. Cutting down prior to stopping smoking (cutting down to quit):

- with the help of one or more licensed nicotine containing products (the products may be used for as long as needed to prevent relapse)
- without using licensed nicotine containing products

### 3. Smoking reduction:

- with the help of one or more licensed nicotine containing products (the products may be used for as long as needed to prevent relapse)
- without using licensed nicotine containing products

### 4. Temporary abstinence from smoking:

- with the help of one or more licensed nicotine containing products
- without using licensed nicotine containing products

The extent to which harm reduction approaches are offered, how these are provided and the range of stakeholders involved should be part of local decision-making. Two implementation documents have been developed – a framework for local conversations on implementing a harm reduction approach and a local implementation matrix – to support local areas with this decision-making.<sup>x</sup>

## Evidence for harm reduction approaches

It should be noted that whilst there is growing evidence to support harm reduction approaches, there are still gaps in the evidence, especially relating to training and clinical interventions. This needs to be considered by any area looking to implement wider harm reduction services.

Currently it is only possible to provide evidence ratings for some of the harm reduction-related interventions as shown in Table 11.

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x These resources can be accessed here: [www.smokefreeaction.org.uk/harmreduct.html](http://www.smokefreeaction.org.uk/harmreduct.html). Any professionals working in tobacco control within the UK who are interested in joining the national Harm Reduction Yammer group are welcome to contact [admin@smokefreeaction.org.uk](mailto:admin@smokefreeaction.org.uk)

**Table 11: Summary of harm reduction-related evidence ratings<sup>y</sup>**

Intervention	Evidence rating
Nicotine-Assisted Reduction to Stop (NARS)/preloading	B
Longer-term use of nicotine replacement therapy to prevent relapse	B
Nicotine replacement therapy for temporary abstinence	B
Electronic cigarettes	C

The research evidence on harm reduction was reviewed by NICE and it is recognised, for example, that there is very limited evidence on cutting down the number of cigarettes alone (without NRT). This has no clear health benefits and does not necessarily lead to smoking cessation. In contrast, cutting down with the use of NRT can result in smoking cessation in the longer term, even amongst smokers who do not initially intend to quit. There is also some evidence that smokers who regularly engage in temporary abstinence with the use of NRT are more likely to go on to stop smoking in the future.

The most consistent evidence for tobacco harm reduction approaches is around 'nicotine- assisted reduction to stop' (NARS) or 'cutting down to quit'. Smokers engage with a structured programme of reduction and aim to move towards stopping in the short to medium term (for example, reducing the number of cigarettes they smoke by at least 50% over four to six weeks before a quit date). However, currently there is limited evidence about the optimum treatment protocol for this type of support and national training is not available. A pilot looking at offering a range of interventions that include reduction programmes was undertaken in 2012 and highlighted a number of areas for further consideration.<sup>z</sup>

Newer nicotine containing products such as electronic cigarettes (see page 23) may have promise as harm reduction or cessation aids, in the same way as NRT. However, these products are not currently licensed for use in the same way as NRT and cannot be provided by stop smoking services. This is likely to change in the future as emerging evidence of effectiveness<sup>139</sup> grows and if some of these products gain a medicinal licence.

### Harm reduction approaches and stop smoking services

Local areas looking to implement some or all of the harm reduction approaches contained within the guidance may identify roles for the local stop smoking service but this should not detract from services supporting smokers to quit in one step using the abrupt cessation model. It is not the responsibility of the existing services to deliver harm reduction, including the provision of longer-term NRT, unless a service has been specifically commissioned and funded to do so.

<sup>y</sup> For an explanation of evidence ratings see page 24

<sup>z</sup> [http://www.ncsct.co.uk/publication\\_routes\\_to\\_quit.php](http://www.ncsct.co.uk/publication_routes_to_quit.php)

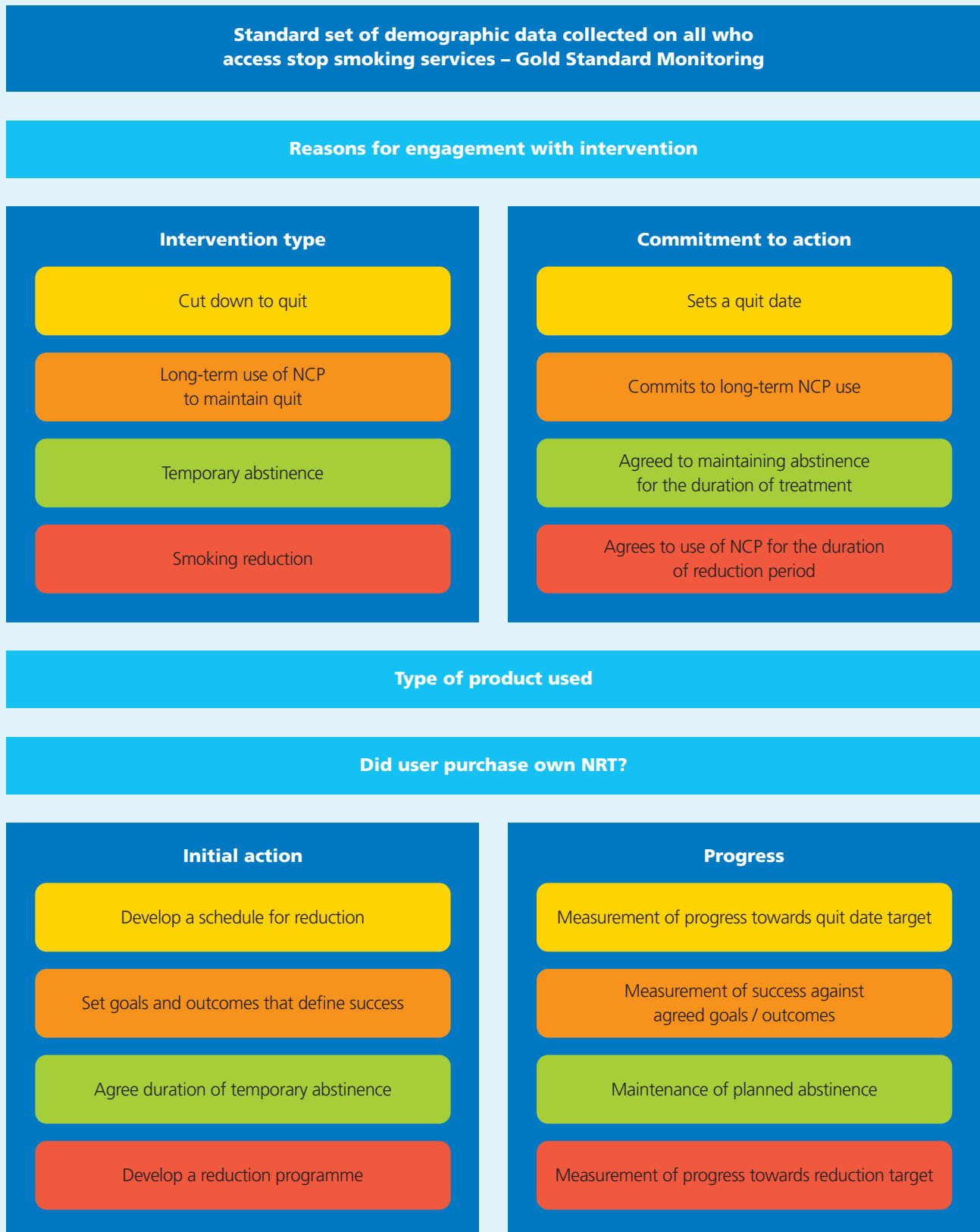
Services who are not directly commissioned to provide any of the NICE recommended harm reduction approaches could still provide smokers with accurate information about safe longer-term use of licensed nicotine containing products. They could also advise any smokers who access the service and feel that they are not ready to stop completely that they could try cutting down using a licensed nicotine containing product (currently NRT) and return to the service when they are ready to quit. Many areas already have protocols in place for the provision of licensed nicotine containing products for temporary abstinence and withdrawal management in, for example, closed institutions.

Some areas are also examining how to encourage nicotine vapouriser users to access their services, including, for example, providing behavioural support to smokers using nicotine vaporisers who may or may not use them alongside a licensed nicotine containing product. Further information on this issue is provided on page 23.

### **Monitoring of harm reduction approaches**

Currently, harm reduction activity is not recorded nationally; however, suggested outcomes that could be captured locally are summarised in Figure 7.

**Figure 7: Harm-reduction monitoring pathway**



Light blue boxes indicate information that is required to be recorded

**Duration of NRT use and quantity of product used****Frequency, duration and type of contract****Outcome**

4-week quit

Maintenance of cessation of smoked tobacco

Did the individual achieve / exceed their goals for abstinence?

Successful maintenance of reduction of levels of smoking using NCP

**Satisfaction with intervention****Extended intervention**

Longer-term outcomes

Did user achieve cessation from nicotine?

Did user go on to maintain abstinence and/or set a quit date?

Did user go on to set quit date?

## References

- 1 Department of Health (2008) *Excellence in Tobacco Control: 10 high impact changes to achieve tobacco control*. DH.
- 2 National Institute for Health and Care Excellence (2008). *Smoking Cessation Services*, (PH10). NICE: <http://publications.nice.org.uk/smoking-cessation-services-ph10>
- 3 NHS Information Centre (2010). *Statistics on Smoking: England, 2010*. NHS Information Centre: Leeds.
- 4 Callum, C., Boyle, S. and Sandford, A. (2010). "Estimating the cost of smoking to the NHS in England and the impact of declining prevalence" in *Health Economics, Policy and Law*. Cambridge Journals online, Cambridge University Press, Cambridge.
- 5 Nash, R. and Featherstone, H. (2010). *Cough up: Balancing tobacco income and costs in society*. Policy Exchange, London.
- 6 Department of Health (2014) *Improving outcomes and supporting transparency Part 1A: A public health outcomes framework for England, 2013–2016 (updated 2014)*. DH: London [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/263658/2901502\\_PHOF\\_Improving\\_Outcomes\\_PT1A\\_v1\\_1.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/263658/2901502_PHOF_Improving_Outcomes_PT1A_v1_1.pdf)
- 7 Chesterman J, Judge K, Bauld L, Ferguson J. How effective are the English smoking treatment services in reaching disadvantaged smokers? *Addiction*. 2005 Apr;100:36–45
- 8 Bauld L, Judge K, Platt S. Assessing the impact of smoking cessation services on reducing health inequalities in England: observational study. *Tob Control*. 2007 Dec;16:400–4.
- 9 Health and Social Care Information Centre (2014) *Statistics on NHS Stop Smoking Services: England, April 2013 to March 2014*. HSCIC: Leeds <http://www.hscic.gov.uk/catalogue/PUB14610/stat-stop-smok-serv-eng-2014-q4-rep.pdf>
- 10 Ebrahim S, Taylor F, Ward K, Beswick A, Burke M, Davey Smith G.(2011) Multiple risk factor interventions for primary prevention of coronary heart disease, Issue 19;(1):CD001561. doi: 10.1002/14651858.CD001561.pub3.
- 11 West R, May S, West M, Croghan E, McEwen A (2013) Performance of English stop smoking services in first 10 years: analysis of service monitoring data. *British Medical Journal*, 47:f4921.
- 12 Bauld L (2014) Longer term outcomes & stop smoking services. Presented at UKNSCC 2014 [http://www.uknsc.org/uknsc2014\\_presentation\\_279.php](http://www.uknsc.org/uknsc2014_presentation_279.php)
- 13 Smoking Toolkit Study, [www.smokinginengland.info](http://www.smokinginengland.info)
- 14 McBride CM, Emmons, KM and Lipkus IM (2003) Understanding the potential of teachable moments: the case of smoking cessation. *Health Education Research*, Vol.18, No.2, 156–170
- 15 Van Stolk C, Starkey T et al (2009) NHS Workforce Health and Wellbeing Review Staff Perception Research. Available from: [http://www.nhshealthandwellbeing.org/pdfs/Interim%20Report%20Appendices/Staff%20Perception%20Survey%20\(Quantitative\).pdf](http://www.nhshealthandwellbeing.org/pdfs/Interim%20Report%20Appendices/Staff%20Perception%20Survey%20(Quantitative).pdf)
- 16 Thornton J, Edwards R, Mitchell P, Harrison R A, Buchan I & Kelly S P (2005) Smoking and age-related macular degeneration: a review of association. *Eye* 19, 935–944)
- 17 Thompson C, Harrison R A, Wilkinson S C, Scott-Samuel A, Hemmerdinger C and Kelly S P (2007) Attitudes of community optometrists to smoking cessation: an untapped opportunity overlooked? *Ophthalmic & Physiological Optics* 27(4):389–393
- 18 National Institute for Health and Care Excellence (2010) *Quitting smoking in pregnancy and following childbirth (PH26)*. NICE: <http://publications.nice.org.uk/quitting-smoking-in-pregnancy-and-following-childbirth-ph26>
- 19 Møller A M, Villebro N, Pedersen T and Tønnesen H (2002) 'Effect of preoperative smoking intervention on postoperative complications: a randomised control trial.' *Lancet* 359(9301):114–7
- 20 Rigotti NA, Munafo MR and Stead LF (2008) 'Interventions for smoking cessation in hospitalised patients'. *Cochrane Database of Systematic Reviews*, Issue 3
- 21 McManus S, Meltzer H and Campion J (2010) *Cigarette Smoking and Mental Health in England: Data from the Adult Psychiatric Morbidity Survey 2007*. National Centre for Social Research.
- 22 Green H, McGinnity A, Meltzer H et al (2005) *Mental Health of Children and Young People in Great Britain, 2004*. Office of National Statistics



- 23 Jochelson J and Majrowski B (2006) *Clearing the air: Debating smoke-free policies in psychiatric units*. King's Fund
- 24 Taylor G, McNeil A et al (2014) Change in mental health after smoking cessation: systematic review and meta-analysis. *BMJ* 2014;348:g1151 <http://www.bmj.com/content/348/bmj.g1151>
- 25 Consuming Passions – the UK National Gay Men's Sex Survey. Hickson. F et al: Sigma Research. 2005
- 26 Ellard J (2010) Smoking Cessation Interventions: A Literature Review. AFAO: [http://www.afa.org.au/\\_\\_data/assets/pdf\\_file/0012/4611/LR10\\_Smoking\\_Cessation\\_Literature.pdf](http://www.afa.org.au/__data/assets/pdf_file/0012/4611/LR10_Smoking_Cessation_Literature.pdf)
- 27 Guasp L et al (2011) *Gay and Bisexual Men's Health Study*. Stonewall.
- 28 Hunt R and Fish J (2008) *Prescription for Change: Lesbian and Bisexual Women's Health Check*. Stonewall.
- 29 National Male Gay/Bisexual Smoking Research: Survey Shop. 2006
- 30 Walls N and Wisenski H (2011) Evaluation of Smoking Cessation Classes for the Lesbian, Gay, Bisexual and Transgender Community.
- 31 NHS England (2013) Domain 2: Enhancing quality of life for people with long-term conditions. Available from: <http://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/>
- 32 Singleton N, Farrell M and Meltzer H (1999) *Substance misuse amongst prisoners in England and Wales*. Office of National Statistics.
- 33 Bala, M, Strzesynski, L and Cahill, K (2008) *Mass media interventions for smoking cessation in adults*, *Cochrane Database of Systematic Reviews*, p. CD004705.
- 34 National Cancer Institute (2008) The role of media in promoting and reducing tobacco use. *Tobacco Control Monograph No. 19*, NIH Pub No. 07–6242. U.S. Department of Health and Human services, Bethesda, MD.
- 35 Chen Y-F, Madan J, Welton N, Yahaya I, Aveyard P, Bauld L, et al. Effectiveness and cost-effectiveness of computer and other electronic aids for smoking cessation: a systematic review and network meta-analysis. *Health Technol Assess* 2012;16(38)
- 36 Scottish Intercollegiate Guidelines Network (2010) *SIGN 50: A guideline developer's handbook*. SIGN
- 37 Brose, L, West, R, McDermott, M, Fidler, J, Croghan, E and McEwen, A (2011) What makes an effective stop smoking service? *Thorax* doi:10.1136/thoraxjnl-2011-200251
- 38 National Institute for Health and Care Excellence (2012) *Smokeless tobacco cessation: South Asian communities (PH39)*. NICE: <http://publications.nice.org.uk/smokeless-tobacco-cessation-south-asian-communities-ph39>
- 39 West R and Aveyard P, internal correspondence for DH
- 40 Hughes JR, Keely J and Naud S (2004) 'Shape of the relapse curve and long-term abstinence amongst untreated smokers.' *Addiction* 99(1):29–38
- 41 Gorber S, Schofield-Hurwitz S, Hardt J, Levasseur G, Tremblay M. The accuracy of self-reported smoking: A systematic review of the relationship between self-reported and cotinine-assessed smoking status. *Nicotine & Tobacco Research* [serial online]. n.d.;11(1):12–24. Available from: Science Citation Index, Ipswich, MA. Accessed May 8, 2014
- 42 West, R. (1,3), Jarvis, M.J.(1.), Zatonski, W.(2.), and Przewozniak, K.(2.), 2007. Can we trust national smoking prevalence figures? Discrepancies between biochemically assessed and self-reported smoking rates in three countries. *Cancer Epidemiology Biomarkers and Prevention*, 16(4), pp. 820–822.
- 43 West R, Fidler J (2011) *Smoking and Smoking Cessation in England 2010*. London: Vasco-Graphics. [www.smokinginengland.info](http://www.smokinginengland.info)
- 44 Aveyard P, Begh R, Parsons A and West R (2012) Brief opportunistic smoking cessation interventions: a systematic review and meta-analysis to compare advice to quit and offer of assistance. *Addiction*. 2012 Jun;107(6):1066–73. doi: 10.1111/j.1360-0443.2011.03770.x. Epub 2012 Feb 28
- 45 Ferguson, J., Bauld, L., Chesterman, J., and Judge, K. (2005) The English smoking treatment services: one year outcomes. *Addiction*, 100 (Supplement 2), pp.59–69
- 46 Whittaker R, Borland R, Bullen C, Lin RB, McRobbie H, Rodgers A. Mobile phone-based interventions for smoking cessation. *Cochrane Database of Systematic Reviews* 2009, Issue 4. Art. No.: CD006611. DOI: 10.1002/14651858.CD006611.pub2

- 47 Free C, Knight R, Robertson S, Whittaker R, Edwards P, Zhou W, Rodgers A, Cairns J, Kenward MG, Roberts I. (2011) Smoking cessation support delivered via mobile phone text messaging (txt2stop): a single-blind, randomised trial. *The Lancet* – 2 July 2011 ( Vol. 378, Issue 9785, Pages 49–55 ) DOI: 10.1016/S0140-6736(11)60701-0
- 48 Hiscock R, Murray S, Brose LS, McEwen A, Bee JL, Dobbie F, Bauld L: Behavioural therapy for smoking cessation: The effectiveness of different intervention types for disadvantaged and affluent smokers. *Addict Behav* 2013, 38:2787-2796
- 49 Heatherton TF, Kozlowski LT, Frecker RC and Fagerstrom KO (1991)'The Fagerstrom Test for Nicotine Dependence: A revision of the Fagerstrom Tolerance Questionnaire.' *British Journal of Addictions* 86 (9):1119–27
- 50 Brose L S, Tombor I, Shahab L and West R (2013) The effect of reducing the threshold for carbon monoxide validation of smoking abstinence – Evidence from the English Stop Smoking Services. *Addictive Behaviours* 38(10):2529–31
- 51 May S and McEwen A (2008) *Stop smoking service provider CO-verification project*. Smoking Cessation Service Research Network
- 52 ASH (2013) Smoking cessation in pregnancy: a call to action. Report of the smoking in pregnancy challenge group, [www.ash.org.uk/files/documents/ASH\\_893.pdf](http://www.ash.org.uk/files/documents/ASH_893.pdf)
- 53 Bauld, L., Hackshaw, L., and Ferguson, J. et al, Implementation of routine biochemical validation and an 'opt out' referral pathway for smoking cessation in pregnancy, 2012, *Addiction*, 107 Supplement 2: 53–60.
- 54 Bailey, B.A, Using expired air carbon monoxide to determine smoking status during pregnancy: preliminary identification of an appropriately sensitive and specific cut-point. *Addict Behav*; 2013 Oct;38(10):2547–50 <http://www.sciencedirect.com/science/article/pii/S0306460313001445>
- 55 Dempsey, D., Jacob, P. and Benowitz, N. L. (2002) 'Accelerated Metabolism of Nicotine Cotinine in Pregnant Smokers'. *The Journal of Pharmacology And Experimental Therapeutics*, Vol. 301, no.2, 594–598
- 56 Benowitz, N. L., Lessov-Schlagger, C. N., Swan, G. E. and Jacob, P. (2006) 'Female sex and oral contraceptive use accelerate nicotine metabolism'. *Clinical Pharmacology & Therapeutics*, 79, 480–88
- 57 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
- 58 Silagy C, Lancaster T, Stead L, Mant D and Fowler G (2004) 'Nicotine replacement therapy for smoking cessation.' *Cochrane Database of Systematic Reviews*, Issue 3
- 59 Bauld L., and Coleman T (2009) The effectiveness of Smoking Cessation Interventions during Pregnancy: A Briefing Paper. NICE: <http://www.nice.org.uk/guidance/index.jsp?action=download&o=45552>
- 60 Coleman, T., Cooper, S., Thornton, J. G., Grainge, M. J., Watts, K., Britton, J., & Lewis, S. (2012). A randomized trial of nicotine-replacement therapy patches in pregnancy. *New England Journal of Medicine*, 366(9), 808–818
- 61 Report of the Committee on Safety of Medicines Working Group on Nicotine Replacement Therapy 2005. London. Medicines and Healthcare Products Regulatory Authority Committee on Safety of Medicines. <http://www.mhra.gov.uk>
- 62 Brose, L.S., McEwen, A., West, R. (2013). Association between nicotine replacement therapy use in pregnancy and smoking cessation. *Drug and Alcohol Dependence* 132 (3):660–664. Doi: 10.1016/j.drugalcdep.2013.04.017
- 63 Champion J, Checinski K, Nurse J (2008) Review of smoking cessation treatments for people with mental illness. *Advances in Psychiatric Treatment*, 14, 208–16
- 64 Kinnunen T, Doherty K, Militello FS and Garvey AJ (1996) 'Depression and smoking cessation: characteristics of depressed smokers and effect of nicotine replacement.' *Journal of Consulting and Clinical Psychology* 64(4): 791–8
- 65 Williams JM and Hughes JR (2003) 'Addressing tobacco use in mental health and addiction settings.' *Psychiatric Annals* 33:457–66
- 66 Williams JM, Ghandi KK, Karavidas MK, Steinberg ML, Lu SE and Foulds J (2008) 'Open-label study of craving in smokers with schizophrenia using nicotine nasal spray compared to nicotine patch.' *Journal of Dual Diagnosis* 4(4):355 –76
- 67 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
- 68 Stead L and Lancaster T (2007) 'Interventions to reduce harm from continued tobacco use.' *Cochrane Database of Systematic Reviews* 2007(3):CD005231

- 69 Lindson, N., Aveyard, P. and Hughes, J. R. Reduction versus abrupt cessation in smokers who want to quit. *Cochrane Database of Systematic Reviews* 2010, Issue 3
- 70 Cahill K, Stead L and Lancaster T (2011) 'Nicotine receptor partial agonists for smoking cessation.' *Cochrane Database of Systematic Reviews* 2011(2):CD006103
- 71 Gunnell D, Irvine D, Wise L, Davies C and Martin RM (2009) 'Varenicline and suicidal behaviour: a cohort study based on data from the General Practice Research Database.' *British Medical Journal* 339:b3805
- 72 Hughes JR, Stead LF, Lancaster T (2007) 'Antidepressants for smoking cessation.' *Cochrane Database of Systematic Reviews* 2007(1):CD000031
- 73 Jarvis MJ and Wardle J (1999) 'Social patterning of individual behaviours: the case of cigarette smoking' in Marmot M and Wilkinson RG (eds) *Social Determinants of Health*. Oxford University Press
- 74 Office for National Statistics (2002) *Smoking Related Behaviour and Attitudes 2002*. ONS
- 75 Roddy E, Antoniak M, Britton J, Molyneux A and Lewis S (2006) 'Barriers and motivators to gaining access to smoking cessation services amongstst deprived smokers – a qualitative study.' *BMC Health Services Research* 6:147
- 76 Wiltshire S, Bancroft A, Parry O and Amos A (2003) "'I came back here and started smoking again": perceptions and experiences of quitting smoking amongst disadvantaged smokers.' *Health Education Research* 18 (3):292–303
- 77 Kotz D and West R (2009) 'Explaining the social gradient in smoking cessation: its not in the trying, it's in the succeeding.' *Tobacco Control*, 18, 43–6
- 78 Hiscock, R., Judge, K. and Bauld, L. (2010) Social inequalities in quitting: What factors mediate the relationship between socioeconomic position and smoking cessation? *Journal of Public Health*, doi: 10.1093/pubmed/fdq097
- 79 Doll R, Peto R, Boreham J and Sutherland I (2004) 'Mortality in relation to smoking: 50 years' observations on male British doctors.' *British Medical Journal* 328:1519
- 80 Critchley JA and Capewell S (2003) 'Smoking cessation for the secondary prevention of coronary heart disease'. *Cochrane Database of Systematic Reviews* Issue 4 (Art.No.:CD003041.DOI:10.1002/14651858.CD003041.pub2.)
- 81 Suskin NS, Sheth T, Negassa A and Yusuf S (2001) 'Relationship of current and past smoking to mortality and morbidity in patients with left ventricular dysfunction'. *Journal of the American College of Cardiology* 37(6): 1677–82
- 82 National Institute for Health and Care Excellence (2013) *Smoking cessation: acute, maternity and mental health services (PH48)*. NICE, London: <http://publications.nice.org.uk/smoking-cessation-in-secondary-care-acute-maternity-and-mental-health-services-ph48>
- 83 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
- 84 Royal College of Physicians (RCP) (1992) *Smoking and the Young: A Report of a Working Party*. Royal College of Physicians, London
- 85 Charlton, A (1996) Children and smoking: the family circle. *British Medical Bulletin* 52, 90–107
- 86 Bastra L, Hadders-Algra M, Neeleman J (2003) Effect of antenatal exposure to maternal smoking on behavioural problems and academic achievement in childhood: prospective evidence from a Dutch birth cohort. *Early Human Development* 75: 21–33
- 87 Wakschlag LS, Pickett KE, Cook E Jr, Benowitz NL and Leventhal BL (2002) 'Maternal smoking during pregnancy and severe antisocial behaviour in offspring: a review.' *American Journal of Public Health* 92(6):966–74
- 88 Button TM, Thapar A and McGuffin P (2005) 'Relationship between antisocial behaviour, attention-deficit hyperactivity disorder and maternal prenatal smoking.' *British Journal of Psychiatry* 187:155–60
- 89 Godfrey C, Pickett KE, Parrott S et al (2010) *Estimating the costs to the NHS of smoking in pregnancy for pregnant women and infants*. York: Department of Health Sciences, The University of York
- 90 Adams E, Solanki G, Miller I. (1995) Medical care expenditures attributable to cigarette smoking in pregnancy – United States, 1995.' *Morbidity and Mortality Weekly Report* 46(44):1045–50
- 91 West R (2002) 'Smoking cessation and pregnancy' *Fetal and Maternal Medicine Review* 13(3) : 181–94
- 92 Owen L, McNeil A (2001) Saliva cotinine as an indicator of cigarette smoking amongst pregnant women. *Addiction* 96(7): 1001–6

- 93 Health and Social Care Information Centre (2012) *Infant Feeding Survey – UK 2010*. HSCIC: Leeds
- 94 Department of Health (2005) *You're Welcome quality criteria: making health services young people friendly*. Department of Health. London
- 95 DH and Department for Children, Schools and Families (2007) *Teenage Parents Next Steps: Guidance for local authorities and primary care trusts*. DCSF
- 96 Tommys (2013) *Baby be smokefree*, <http://www.tommys.org/page.aspx?pid=753>
- 97 Kumari V and Postma P (2005) 'Nicotine use in schizophrenia: the self medication hypotheses.' *Neuroscience and Biobehavioural Reviews* 29: 1021–34
- 98 Brown S, Kim M, Mitchell C et al (2010) Twenty-five year mortality of a community cohort with schizophrenia. *BJPsych*, 196, 116–121
- 99 Saha S, Chant D, McGrath J A (2007) Systematic review of mortality in schizophrenia: Is the differential mortality gap worsening over time? *Arch Gen Psychiatry*, 64, 1123–1131 <http://archpsyc.ama-assn.org/cgi/content/full/64/10/1123>
- 100 Cuijpers P, Smit F, et al (2007). Smoking is associated with first-ever incidence of mental disorders: a prospective population-based study. *Addiction*. 102(8): 1303
- 101 Malone KM, Waternaux C, Haas GL et al. (2003) 'Cigarette Smoking, Suicidal Behaviour, and Serotonin Function in Major Psychiatric Disorders.' *American Journal Psychiatry*. 160(4): 773–9
- 102 McNally, L. and Ratschen, E. (2010) The Delivery of Stop Smoking Support to People with Mental Health Conditions: A Survey of NHS Stop Smoking Services. *BMC Health Services Research*, 10:179
- 103 Farrell M, Howes S, Bebbington P et al. (2001) 'Nicotine, alcohol and psychiatric morbidity: Results of a national household survey.' *British Journal Psychiatry*, 179: 432–7
- 104 Champion 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
- 105 Taylor G, McNeill A, Girling A et al (2014) Change in mental health after smoking cessation: systematic review and meta-analysis. *BMJ* 2014;348:g1151
- 106 Hughes JR (2007) 'Depression during tobacco abstinence.' *Nicotine Tobacco Research* 9(4):443–6
- 107 Banham, L. and Gilbody, S. (2010) Smoking cessation in severe mental illness: what works? *Addiction*, 105(7):1176–89
- 108 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* 30:400–12
- 109 Phelan M, Stradins L and Morrison S (2001) 'Physical health of people with severe mental illness.' *British Medical Journal* 322: 443–4
- 110 Szatkowski L & McNeill A. The delivery of smoking cessation interventions to primary care patients with mental health problems. *Addiction* 2013 doi 10.1111/add.12163
- 111 Parker C, McNeill A, Ratschen E. Tailored tobacco dependence support for mental health patients: a model for inpatient and community services. *Addiction*. 2012 Dec;107:18–25.
- 112 Miller N and Gold M (1998) 'Comorbid cigarette and alcohol addiction: epidemiology and treatment.' *Journal of Addictive Disorders* 17:55–66
- 113 Dierker LC, Avenevoli S, Stolar M et al. (2002) 'Smoking and depression: An examination of mechanisms of comorbidity.' *American Journal Psychiatry*, 159:947–53
- 114 John U, Meyer C, Rumpf HJ et al. (2004) 'Smoking, nicotine dependence and psychiatric comorbidity – a population-base study including smoking cessation after three years.' *Drug and Alcohol Dependence* 76:287–95
- 115 Williams JM and Ziedonis DM (2004) 'Addressing tobacco amongst individuals with a mental illness or an addiction.' *Addictive Behaviours* 29:1067–83
- 116 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
- 117 Hendricks, P. S., Peters, E. N., Thorne, C. B., Delucchi, K. L., and Hall, S. M. Expectancies for smoking cessation amongst drug-involved smokers: Implications for clinical practice. *Journal of Substance Abuse Treatment*. 29-10-2013

- 118 Office for National Statistics (2012) *Ethnicity and National Identity in England and Wales 2011*. ONS
- 119 BHF. Rise in 'shisha bars' prompts warning on dangers of waterpipe smoking. Secondary Rise in 'shisha bars' prompts warning on dangers of waterpipe smoking 2012. <http://www.bhf.org.uk/default.aspx?page=14417>
- 120 Jawad M, Lee JT, Wilson A, et al. Waterpipe and cigarette smoking amongst secondary school students in London: a comparison of prevalence, beliefs, cessation and predictors. *Nicotine and Tobacco Research*. 2013. [Epub ahead of print]
- 121 Jawad M, Abass J, Hariri A, et al. Waterpipe smoking prevalence and attitudes amongstst medical students in London. *International Journal of Tuberculosis and Lung Disease* 2013;17(1):1–4
- 122 Jackson D, Aveyard P. Waterpipe smoking in students: prevalence, risk factors, symptoms of addiction, and smoke intake. Evidence from one British university. *BMC public health* 2008;8
- 123 Munshi M, Breen R. Waterpipe Smoking amongstst London Medical Students. San Diego Conference Centre, 2009.
- 124 Jawad M, Albeyatti A, Ananthavarathan P, et al. *Knowledge and attitudes of waterpipe tobacco smoking (shisha) amongst General Practitioners in two areas of the United Kingdom* (unpublished data)
- 125 Sproston K, Mindell J (2006) *Health Survey for England 2004, Vol 1: the Health of Minority Ethnic groups*. London, Information Centre.
- 126 Croucher R, Islam S, Jarvis MJ et al. (2002) Tobacco dependence in a UK Bangladeshi female population: a cross-sectional study. *Nicotine and Tobacco Research*, 4 (2): 171–176
- 127 McNeill A, Pritchard C, Longman J, Leonardi-Bee J, Myles P, Aveyard P et al. (2010) *Smokeless tobacco in the UK – products, populations and policy*. UK Centre for Tobacco Control Studies, University of Nottingham; May 2010. Contract No.: C25586 A9756. Sponsored by Cancer Research UK
- 128 Stanfill SB, Connolly GN, Zhang L, Jia LT, Henningfield JE, Richter P et al. (2011) Global surveillance of oral tobacco products: total nicotine, unionised nicotine and tobacco-specific n-nitrosamines. *Tobacco Control*, 20 (3), e2
- 129 Critchley JA, Unal B (2003) Health effects associated with smokeless tobacco: a systematic review. *Thorax*, 58:435–438
- 130 Scientific Committee on Emerging and Newly Identified Health Risks (SCENIHR) (2007) *Health Effects of Smokeless Tobacco Products*. Brussels: European Commission, Health and Consumer Protection
- 131 Akl EA, Gaddam S, Gunukula SK et al. (2010) The effects of waterpipe tobacco smoking on health outcomes: A systematic review, *International Journal of Epidemiology*, 39, 834–857
- 132 Croucher R, Islam S, Jarvis MJ et al. (2002) Tobacco dependence in a UK Bangladeshi female population: a cross-sectional study. *Nicotine and Tobacco Research*, 4 (2): 171–176
- 133 Croucher R, Islam S, M.J J, Garrett M et al. (2003) Oral tobacco cessation with UK resident Bangladeshi women: a community pilot investigation. *Health Education Research Theory and Practice*, 18(2):216–23
- 134 Thomas RE, McLellan J, Perera R. School-based programmes for preventing smoking. *Cochrane Database of Systematic Reviews* 2013, Issue 4. Art. No.: CD001293. DOI: 10.1002/14651858.CD001293.pub3
- 135 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
- 136 Hughes JR and Carpenter MJ (2006) 'Stopping smoking: carpe diem?' *Tobacco Control* 15:415–16
- 137 Office for National Statistics (2005) *The National Statistics Socio-economic Classification User Manual*. ONS
- 138 National Institute for Health and Care Excellence (2013) *Tobacco: harm reduction approaches to smoking (PH45)*. NICE: <http://publications.nice.org.uk/tobacco-harm-reduction-approaches-to-smoking-ph45>
- 139 Brown J, Beard E, Kotz D, Michie S, and West R (2014) Real-world effectiveness of e-cigarettes when used to aid smoking cessation: A cross-sectional population study. *Addiction*109: doi: 10.1111/add.12623





