NHS STOP SMOKING SERVICES

Service and monitoring guidance 2010/11
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NHS STOP SMOKING SERVICES

Service and monitoring guidance 2010/11
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Mark Brown – Senior Public Health Development Adviser, NHS Manchester
Heather Thomson – Health Improvement Manager, NHS Leeds Primary Care Trust
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ABBREVIATIONS

AMD  Age-related macular degeneration
BME  Black and minority ethnic
CO   Carbon monoxide
COPD Chronic obstructive pulmonary disease
CQC  Care Quality Commission
CQUIN Commissioning for Quality and Innovation
CRM  Customer relationship management
DH   Department of Health
FTND Fagerström test for nicotine dependence
HCP  Healthcare professional
HDA  Health Development Agency
HSE  Health and Safety Executive
IC   NHS Information Centre
IHS  Integrated Household Survey
LA   Local authority
LAA  Local Area Agreement
LES  Local Enhanced Service
LTFU Lost to follow-up
MHRA Medicines and Healthcare products Regulatory Agency
NARS Nicotine-Assisted Reduction to Stop
NCSCT NHS Centre for Smoking Cessation and Training
NICE National Institute for Health and Clinical Excellence
NNT Numbers needed to treat
NST  National support team
NRT  Nicotine replacement therapy
NZGG New Zealand Guidelines Group
PCT  Primary care trust
PGD  Patient group directions
PSA  Public Service Agreement
ONS  Office for National Statistics
QOF  Quality and Outcomes Framework
RCM  Regional communications manager
RCT  Randomised controlled trial
RDM  Regional development manager
R/M  Routine and manual
RTPM Regional tobacco policy manager
SHA  Strategic health authority
Using this document

Please note that this document is split into three sections: commissioning, delivering and monitoring. Key terms can be found in the Definitions section in Annex D (see page 94), while highlighted words link to other areas of the document.

The research on which this guidance is based is fully referenced throughout.
EXECUTIVE SUMMARY

- This updated guidance is useful for primary care trusts (PCTs) that have selected smoking prevalence, infant mortality and/or all-age, all-cause mortality as World Class Commissioning (WCC) priorities (see World Class Commissioning on page 32).

- The provision of high-quality NHS Stop Smoking Services is a high priority. Since their beginning 10 years ago they have supported over 2 million people to stop in the short term and 500,000 people to stop long term, saving 70,000 lives.

- Stop smoking services are a key part of tobacco control and health inequalities policies both at local and national levels.1

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

Targeting groups

- Many smokers will need to make multiple attempts to quit before achieving long-term success; it is important that those who are motivated receive repeat interventions following a relapse.

- In line with National Institute for Health and Clinical Excellence (NICE) best practice recommendations, service providers should aim to treat a minimum of 5% of their local population of smokers in the course of a year.2

- To work most effectively, services should focus on specific segments of the population – in particular, increasing access for smokers from routine and manual (R/M) groups, as quit rates are still lower for these groups than for those in higher socio-economic groups.

- Services also need to increase access for black and minority ethnic (BME) groups with high smoking rates (e.g. Bangladeshi men). Prisoners and those with mental illness also have very high levels of smoking and it is important that appropriate services are made available to these groups as well as pregnant smokers.

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

Delivering services

- Four-week quit smoking rates are the local measure to reflect smoking prevalence as set out in Tier 2 Vital Signs in the NHS Operating Framework. They are also a National Indicator (N123) in the Local Area Agreement (LAA) process. They provide a useful performance measure for NHS Stop Smoking Services and a means of tracking service performance against local operating plans.


• Smokers attempting to stop without additional support 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 effect, services must achieve success rates in excess of these.

• Evidence-based guidelines\(^3\) and NICE guidance should inform how services are delivered and the availability of smoking cessation aids (see Pharmacotherapy on page 50).

• To optimise success, all NICE recommended pharmacotherapies need to be offered as a first-line intervention.

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

Data and monitoring

• The full and accurate completion of individual client data monitoring forms, and their timely submission to the service, is a condition for qualifying as an NHS Stop Smoking Service provider (see Monitoring NHS Stop Smoking Services on page 84).

• Four-week quit data is required in order to assess the cost-effectiveness of defined stop smoking interventions. This may not include information on people who have stopped smoking (‘four-week quits’) without interventions delivered by stop smoking advisers (see Definitions on page 94).

Maintaining standards

• Commissioning is a key lever for meeting service requirements.

• Commissioners and providers need to work together to achieve optimum outcomes using evidence-based interventions, focusing jointly on increasing reach and access for smokers from target groups, improving data quality and ensuring that resources are allocated appropriately.

• All stop smoking advisers need to receive specific training to carry out their role. Any training should conform to the standards set out by the Health Development Agency’s (HDAs) training standards document or its updates (see note below)\(^4\).

• To achieve best practice, all service delivery models should also conform to established quality principles (see page 26).

• As part of the Government’s commitment to modernise and improve treatment for smokers who wish to stop, the NHS Centre for Smoking Cessation and Training (NCSCT) was set up in 2009/10. The NCSCT will provide a number of key products and services, including national training standards and nationally accredited training programmes for stop smoking practitioners and best practice delivery models based on the latest research evidence.

• Note: from 1 April 2010, the NCSCT national training standards will supersede the HDA standard as the official benchmark of quality training for stop smoking service personnel in England. The standards will be available to all at www.ncsct.co.uk.

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Since their foundation 10 years ago, NHS Stop Smoking Services have supported over 2 million people to stop in the short term and 500,000 people to stop long term, saving 70,000 lives.

This document provides best practice guidance relevant to the provision of all NHS stop smoking interventions and sets out fundamental quality principles for the delivery of services, which can be used to inform the development of local commissioning arrangements. It also includes full details of the data reporting requirements for NHS Stop Smoking Services. We therefore urge service commissioners and public health and primary care trust (PCT) leads to note the changes and additions to this guidance and to refer to it in the course of their endeavours to provide high-quality services for smokers who want to stop. Smoking is one of the most significant contributing factors to life expectancy, health inequalities and ill health, particularly cancer, coronary heart disease and respiratory disease (see Lung health and chronic obstructive pulmonary disease on page 48). Reducing smoking is therefore a key improvement area within the overarching health and well-being Public Service Agreement (PSA 18) area, and this is reflected in strategic health authority (SHA) Local Delivery Plans, within the NHS Operating Framework, and in Local Area Agreements (LAAs).

The Health and well-being for all PSA 18 states ‘Tackle the underlying determinants of ill health and health inequalities by: reducing adult smoking rates to 21% or less by 2010, with a reduction in prevalence among routine and manual groups to 26% or less.’

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

Current smoking rates in England are 21% overall, and 26% for R/M groups. Smoking prevalence is highest in deprived communities. Progress against the PSA target for R/M smokers (reduction from 33% in 2001 to 26% in 2010) has historically been slower relative to that of other population groups. A high level of intervention is vital to deliver effective, cross-social group reach on this, the biggest single public health issue. Reducing smoking prevalence in the Spearhead Group of local authorities (LAs) and the PCTs which map to them is also a key intervention to meet the health inequalities, life

expectancy, infant mortality and all-age, all-cause mortality (increasing life expectancy), as well as the inequalities elements of the cardiovascular disease and cancer PSA targets.

Current strategic policy objectives have been formulated to achieve the following:

1. **Modernise NHS Stop Smoking Services**: improve treatment effectiveness, performance management and access to effective treatment through NHS support services and helplines.

2. **Improve the effectiveness of pharmacotherapy** usage and develop the evidence base for a harm reduction strategy.

3. **Improve the evidence base** for smoking cessation work and intelligence on the efficacy of interventions.

To meet these goals, the Department of Health (DH) is funding a number of programmes designed to improve referral rates from key settings (primary and secondary care). It is committed to the development and delivery of nationally accredited and evidence-based training and professional development systems for NHS stop smoking practitioners. DH is also funding a national support team (NST) to help areas improve the effectiveness of tobacco control interventions at a local level through partnerships with a focus on R/M smokers (www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_101224). Related work is also underway, working with LAs and the Improvement and Development Agency, to identify ways of reducing R/M smoking prevalence through wider tobacco control in community settings.

**New strategy for tobacco**

DH is due to publish the new strategy for tobacco by the end of 2009; this will focus on the following three themes:

- Reducing the number of new smokers
- Helping every smoker to stop
- Protecting communities from harm.
The NHS Centre for Smoking Cessation and Training (NCSCT) was set up in April 2009 and is being funded by DH to develop evidence-based national standards for smoking cessation training, competence-based training programmes and professional development systems for the NHS stop smoking workforce. The intention behind this development is that anyone working for an NHS Stop Smoking Service will be able to prove to themselves, their employer and the public that they have the necessary knowledge and skills to deliver effective smoking cessation interventions.

Knowledge competences (Stage 1 training) will be assessed online and this facility will be open to all stop smoking practitioners, managers and commissioners from 1 April 2010. On passing the Stage 1 assessment, individuals will be eligible for preliminary NCSCT certification. Skill-based competences (Stage 2 training) will be taught and assessed during face-to-face training courses and subsequent assessments. On passing the Stage 2 assessment, practitioners will be eligible for full NCSCT certification. The NCSCT will also be providing training for NHS Stop Smoking Service managers and commissioners and will develop regular update training courses to ensure that all stop smoking service staff and service users are able to benefit from the latest research developments.

Initially the NCSCT will be targeting Stage 2 (skills) training at those services who face the greatest challenges in terms of high levels of deprivation, service performance and high smoking prevalence, but it is planned that by 31 March 2012 all NHS Stop Smoking Services will have been given the training necessary to provide high-quality service delivery. Training will initially be delivered by the NCSCT’s training partners but during 2010 the organisation will be developing a system whereby external trainers and training courses can be accredited, to ensure good national coverage of high-quality training. Information about opportunities for accreditation and the training delivery programme will be posted on the NCSCT website when available (www.ncsct.co.uk).

Note: from 1 April 2010, the NCSCT national training standards will supersede the Health Development Agency (HDA) standard as the official benchmark of quality training for stop smoking service personnel in England. The standards will be available to all at www.ncsct.co.uk.

These guidelines

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

It has been developed in collaboration with representatives from national support teams (NSTs), SHAs, PCTs and the NHS Information Centre (IC) as well as academics from the field of smoking cessation. It supersedes all earlier DH smoking cessation guidelines.
This document therefore reflects the full range of NHS Stop Smoking Services now available in England and shows how they can be applied to priority population groups, such as R/M smokers (see page 63), smokers from black and minority ethnic (BME) groups (see page 68), smokers with mental health problems (see page 70) and pregnant smokers (see page 74), as well as to prisoners who smoke (see page 78).

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

Note: to ensure that guidance remains up to date, this document will be revised annually.

EVIDENCE RATING OF RECOMMENDATIONS

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

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

NHS Stop Smoking Services are now well established and are delivering substantial numbers of successful four-week quitters. The services provide around a quarter of all successful quits per annum and have been praised by the Care Quality Commission (CQC) (formerly know as the Healthcare Commission) for the contribution they make to the national health inequalities agenda. They therefore remain a key element of the Government’s overall tobacco control strategy.
The primary role of NHS Stop Smoking Services is to provide a high-quality clinical smoking cessation service to their local population. They should not be regarded as the main driver for reducing smoking prevalence, which is affected to a much greater degree by national policy and local tobacco control strategies. NHS Stop Smoking Services should sit within an overall tobacco control programme and should form a part of wider action to reduce local smoking prevalence.7

In the course of a year, services should aim to treat at least 5% of the local population of smokers, in line with best practice recommendations contained within National Institute for Health and Clinical Excellence (NICE) programme guidance for smoking cessation.8 By supporting local smokers who want to stop they can help reduce health inequalities and have a significant long-term impact on local and national smoking prevalence.

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

Targeting services

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

Targeting priority groups

It should be noted, however, that routine and manual (R/M) smokers make up 44% of the overall smoking population. Targeting this group should therefore be a priority for NHS Stop Smoking Services. Commissioners will need to monitor throughput and success rates, aiming for a minimum throughput of R/M smokers that is at least proportionate to the local smoking population, and maximising and sustaining potential quits by ensuring that the most effective and well-evidenced approaches are used. For further information and recommendations regarding this important client group see page 63 or www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_101224.

Other groups that require proportionate targeting include black and minority ethnic (BME) communities and pregnant women, as well as smokers with mental health problems and prisoners (see pages 68–80).

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8 National Institute for Health and Clinical Excellence (2008) Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities. NICE. www.nice.org.uk/Guidance/PH10
### Table 1: Distribution of R/M smokers by region

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<tr>
<td>North East</td>
<td>6</td>
<td>29</td>
</tr>
<tr>
<td>North West</td>
<td>17</td>
<td>28</td>
</tr>
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<td>Yorks and The Humber</td>
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<td>22</td>
</tr>
<tr>
<td>South West</td>
<td>10</td>
<td>25</td>
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</table>

Source: ONS, 2009.

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### Balancing reach and efficacy

Ideally, NHS Stop Smoking Services should combine interventions that are appropriate to the needs, preferences and diversity of their local smoking population, while being particularly mindful of reaching those with health and social inequality. There is evidence to show an inverse relationship between numbers treated and success rates, with a drive for high numbers resulting in lower success rates. Therefore, commissioners will need to balance the need for widely accessible services against the need for high efficacy rates. Some interventions, such as online or telephone support, reach high volumes of smokers, but may be less intensive and therefore less effective. Interventions such as closed groups (see page 39) are highly effective and should form part of the overall service delivery but will need sustained, effective local promotion to ensure throughput.

Note: Smokers attempting to stop without additional support 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 effect, services should achieve success rates in excess of these.

### Efficacy and choice

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

For example, since gaining NICE approval in October 2007, Champix (varenicline) has proved to be a highly cost-effective treatment, resulting in average success rates of...
61% at four weeks during 2008/09\(^\text{10}\) (see page 58). Since all motivated quitters should be given the optimum chance of success in any given quit attempt, nicotine replacement therapy (NRT), Champix (varenicline) and Zyban (bupropion) should all be made widely available in combination with intensive behavioural support as a first-line treatment (where clinically appropriate).

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

**Figure 1: Effectiveness of pharmacotherapy and support options**

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

<table>
<thead>
<tr>
<th>No medication</th>
<th>Mono NRT</th>
<th>Combination NRT</th>
<th>Bupropion</th>
<th>Varenicline</th>
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<tbody>
<tr>
<td>No support</td>
<td>16%</td>
<td>25%</td>
<td>28%</td>
<td>37%</td>
</tr>
<tr>
<td>Individual behavioural support</td>
<td>22%</td>
<td>37%</td>
<td>39%</td>
<td>52%</td>
</tr>
<tr>
<td>Group behavioural support</td>
<td>32%</td>
<td>50%</td>
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</tbody>
</table>

Source: Cochrane Database of Systematic Reviews\(^\text{11}\)

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\(^\text{11}\) Cahill K, Stead LF and Lancaster T (2008) 'Nicotine receptor partial agonists for smoking cessation.' Cochrane Database of Systematic Reviews, Issue 3
Stead LF, Perera R and Lancaster T (2006) 'Telephone counselling for smoking cessation.' Cochrane Database of Systematic Reviews, Issue 3
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
Stead LF and Lancaster T (2005) 'Group behaviour therapy programmes for smoking cessation.' Cochrane Database of Systematic Reviews, Issue 2
Hughes JR, Stead LF and Lancaster T (2007) 'Antidepressants for smoking cessation.' Cochrane Database of Systematic Reviews, Issue 1
Table 2: Effectiveness of pharmacotherapy and support options

<table>
<thead>
<tr>
<th>Four-week quit rates</th>
<th>No medication</th>
<th>Mono NRT</th>
<th>Combination NRT</th>
<th>Bupropion</th>
<th>Varenicline</th>
</tr>
</thead>
<tbody>
<tr>
<td>No support</td>
<td>16%</td>
<td>25%</td>
<td>36%</td>
<td>28%</td>
<td>37%</td>
</tr>
<tr>
<td>Individual behavioural support</td>
<td>22%</td>
<td>37%</td>
<td>50%</td>
<td>39%</td>
<td>52%</td>
</tr>
<tr>
<td>Group behavioural support</td>
<td>32%</td>
<td>50%</td>
<td>71%</td>
<td>55%</td>
<td>74%</td>
</tr>
</tbody>
</table>

Source: Cochrane Database of Systematic Reviews

Table 3: Intervention success rates

<table>
<thead>
<tr>
<th>Intervention type</th>
<th>Estimated four-week success rate range</th>
</tr>
</thead>
<tbody>
<tr>
<td>One-to-one support</td>
<td>22%–52%*</td>
</tr>
<tr>
<td>Couple/family support</td>
<td>Insufficient evidence</td>
</tr>
<tr>
<td>Closed group support</td>
<td>32%–74%*</td>
</tr>
<tr>
<td>Open (rolling) group support</td>
<td>Insufficient evidence</td>
</tr>
<tr>
<td>Drop-in support</td>
<td>Insufficient evidence</td>
</tr>
<tr>
<td>Telephone support</td>
<td>22%–51%*</td>
</tr>
<tr>
<td>Online support</td>
<td>28%–66%*</td>
</tr>
</tbody>
</table>

Notes:
* Indicates success range by intervention type from clients receiving no medication to those receiving NRT, bupropion or varenicline.
  
† Indicates availability of little or no published research evidence regarding the efficacy of these intervention types and therefore insufficient available data to estimate four-week success rates.
  
‡ The indicative four-week success rate from existing studies of online support. Evidence of success rates of online support combined with medication are not currently available.

**Delivering interventions**

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

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

correct specific client problems

CO-verify quit status four weeks from the quit date

plan ongoing coping mechanisms, support and pharmacotherapy at the end of treatment

assess client satisfaction with the intervention provided.

MEASURING CLIENT SATISFACTION

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

The validated tool can be found at Annex E (page 99) while details of a larger-scale evaluation that is currently underway can be found at the web address given above.

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

The results also show that closed group provision is significantly more effective, with average success rates of 64% compared with 49% for one-to-one treatment. The changes in delivery approaches have therefore led to an overall decline in treatment efficacy, which needs to be addressed at national, regional and local levels.


### Table 4: Stop smoking experimental statistics

Number of smokers setting a quit date and successful quitters by intervention type and setting, April 2008 to March 2009.

<table>
<thead>
<tr>
<th>England</th>
<th>Numbers/percentages</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number setting a quit date</td>
<td>Number of successful quitters</td>
</tr>
<tr>
<td><strong>Intervention type</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Closed group</td>
<td>18,123</td>
<td>11,553</td>
</tr>
<tr>
<td>Telephone support</td>
<td>6,920</td>
<td>4,380</td>
</tr>
<tr>
<td>Couple/family</td>
<td>4,764</td>
<td>2,641</td>
</tr>
<tr>
<td>Open (rolling) group</td>
<td>31,089</td>
<td>17,154</td>
</tr>
<tr>
<td>One-to-one support</td>
<td>526,346</td>
<td>260,162</td>
</tr>
<tr>
<td>Drop-in</td>
<td>63,926</td>
<td>31,596</td>
</tr>
<tr>
<td>Other</td>
<td>20,088</td>
<td>9,567</td>
</tr>
<tr>
<td>Unknown</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>671,259</td>
<td>337,054</td>
</tr>
</tbody>
</table>

| **Intervention setting** | | | |
| Prison | 9,907 | 5,996 | 61 |
| Stop Smoking Services | 193,159 | 104,559 | 54 |
| Military base | 3,048 | 1,664 | 55 |
| Hospital ward | 7,411 | 4,069 | 55 |
| Primary care | 316,990 | 154,911 | 49 |
| Dental practice | 703 | 342 | 49 |
| Pharmacy | 116,212 | 53,935 | 46 |
| Other | 23,829 | 11,578 | 49 |
| **Total** | 671,259 | 337,054 | 50 |

**Notes:**

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

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

Source: Adapted from NHS Information Centre

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**Establishing quitter smoking status**

There are a number of well-established biochemical methods for establishing smoking status in individuals attempting to quit (see page 44). The most cost-effective and least invasive of these is the measurement of expired air CO. Since self-reported smoking status can be unreliable, CO validation rates are important markers of data quality.
The 2009/10 guidance update recommended that services should aim for a minimum CO validation rate of 85% (of all reported four-week quits). Although some services have made efforts to improve their rates, April 2008 to March 2009 data indicates that, on average, services are achieving CO validation rates of around 67%. There is therefore some way to go before achieving the recommended level.

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

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

**Measuring success**

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

The use of the four-week point as a measure of clinical outcome (stop smoking success) has been questioned, but if the quality of smoking status data at four weeks is good (and is supported by high rates of CO validation) then longer-term success rates can be calculated with a high degree of accuracy. This is because relapse rates for smoking are predictable and well documented in the research literature (see page 82).

Where resources allow, longer-term follow-up data, e.g., at 12 weeks and 52 weeks, can provide a further check of efficacy, especially for sub-populations or specific pilot projects. In general, however, following up service users over long periods of time can become very resource-intensive, as many of them will have changed their address or contact details. NHS Stop Smoking Services are therefore not required to supply this level of data – but they need to ensure that sufficient resources are in place to complete four-week follow-ups as these provide essential monitoring data.

NHS Stop Smoking Services provide around a quarter of all successful quits per annum but wider, comprehensive action on tobacco control will be required if we are to drive down smoking prevalence in England. This will require effective partnership action at national, regional and local levels. Local Authorities (LAs) will continue to have a key role to play in tackling smoking prevalence. We will be working with the data from the Integrated Household Survey (IHS), when it becomes available, to explore how best this could link to performance frameworks and the new strategy and delivery plan for tobacco will provide Local Authorities with more guidance.
Working with other service providers

NHS Stop Smoking Services should not be expected to work in isolation and should instead be seen as providing the core to a wider network of referrers. Smoking cessation has been linked to the potential for teachable moments\(^\text{16}\) meaning that all healthcare professionals (HCPs) can potentially have a positive impact on a smoker’s decision to stop. The systematic provision of brief interventions and routine referral of smokers to NHS Stop Smoking Services should therefore be written into all provider contracts including those for health visitor, school nursing and district nursing services.

Stop smoking service leads and commissioners need to ensure that SLAs or Local Enhanced Service (LES) contracts with service providers include clear criteria for delivery and reporting requirements (with deadlines for data return). All staff involved in this work should be trained, either by the service or in-house,\(^\text{17}\) to provide stop smoking interventions. Service delivery in all settings will need to be spot-checked at regular intervals to ensure that the intervention being provided is of acceptable quality and duration. Providers that fail to return data within the prearranged deadlines should be made aware that payments will not be made for late data. Commissioners should determine the level of payment for in-house support according to the time and duration of interventions given, as well as team inputs for data handling. It is not recommended that service providers are remunerated for referrals.

PRIMARY CARE SERVICES

Primary care is a key setting for stop smoking interventions and an important source of referrals to NHS Stop Smoking Services. Helping smokers to quit is a key part of the remit of all primary care staff and therefore service leads need to ensure that all local GPs and other HCPs (e.g. practice nurses, district nurses, midwives and health visitors) are aware of the AAA model for the provision of brief advice and referral of smokers to the local NHS Stop Smoking Service (see page 38).

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

PHARMACIES

Pharmacies have a good track record of providing stop smoking services to the general public. Ideally placed to provide this service, they are based in the heart of communities and are accessible to people who may not access NHS services. They provide a readily available network of trusted health professionals and are ideally placed to provide credible and reliable information and promote health and well-being. Hospital-based pharmacies can also play an important role in developing and delivering stop smoking services in acute settings.


\(^{17}\) Health Development Agency (2003) \textit{Standard for training in smoking cessation treatments}. HDA. \url{www.nice.org.uk/aboutnice/whoweare/aboutthehda/hdapublications/standard_for_training_in_smoking_cessation_treatments.jsp}

The community pharmacy contractual framework requires all pharmacies in England to provide opportunities and prescription-linked healthy lifestyle advice to patients presenting prescriptions for diabetes, those who may be at risk of heart disease, those who smoke and those who are overweight. In addition, pharmacies are required to participate in six public health campaigns each year, organised by the primary care trust (PCT).

Commissioners and service leads should be encouraged to commission services from pharmacies and should continue to work in partnership with them to develop high-quality stop smoking services that the general public can access easily.

**DENTISTS**

Almost 60% of the adult UK population visit a dentist for regular check-ups, including a high proportion of young people aged 25–35. Dentists also have regular contact with pregnant women and teenagers, who are important groups for referral. Dental teams are therefore well placed to offer brief advice and refer smokers to their local NHS Stop Smoking Service. Where appropriate they can provide in-house intensive stop smoking support.18 Hospital-based dental teams can also help to develop stop smoking services in acute settings.

In addition to smokers, dentists are also ideally placed to identify users of smokeless tobacco. There is evidence to show the use of smokeless tobacco products (e.g. chewing tobacco, paan, khat) can have negative health effects, including oral cancers. There is some evidence to suggest that behavioural support can be effective; however, there is a significant lack of evidence to suggest the most effective intervention.

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

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PART 1: COMMISSIONING

OPTOMETRISTS

There is a strong association between smoking and age-related macular degeneration (AMD). Currently there is no effective treatment for all types of AMD and therefore identifying modifiable risk factors is of great importance.19

Thompson et al (2007)20 assessed the attitudes and current behaviour regarding provision of smoking cessation advice among community optometrists working in north-west England. To achieve this a postal questionnaire was sent to community optometrists identified from the General Optical Council’s practice lists. The results showed low levels of current involvement, with only 6.2% of respondents routinely asking about smoking during new patient consultations and 2.2% raising the issue of smoking at follow-up visits. However, the majority (67.6%) stated they wished to increase their knowledge of smoking and visual impairment, with 56.2% requesting further training.

The authors concluded that optometrists provide a further opportunity to deliver brief interventions to smokers and to promote and refer to stop smoking services.

MATERNITY SERVICES

Maternity services play a key role in identifying and referring pregnant smokers or women who smoke and are trying to conceive, to NHS Stop Smoking Services. Referrals should be made as early as possible and can be made, for example, when booking the first midwife visit (see page 75).

SECONDARY CARE

Smokers are more likely to experience postoperative complications and slower wound healing,21 which can result in the need for further surgery, a longer hospital stay and increased costs to the health service. Being admitted to hospital has been shown to increase a patient’s motivation to stop smoking. A Cochrane Review found that patients offered support to stop smoking as part of their inpatient activity, including community follow-up for at least four weeks post-discharge, improved abstinence rates significantly.22

Both primary and secondary care staff play a pivotal role in referring smokers for stop smoking support as soon as possible prior to planned admissions. In the case of unplanned admissions, staff also need to ensure access to pharmacotherapy for withdrawal management.

MENTAL HEALTH SERVICES AND PRISONS

Given that up to 70% of people in mental health units smoke, mental health services are an important source of referrals to stop smoking services. The majority of those with mental illness are managed in primary care and community health services, therefore established care pathways are recommended to facilitate improved access to stop smoking support. Prisons are also an important source of referrals, where 80% of the population smoke.

HEALTH TRAINERS

Health trainers 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 the AAA approach (see page 38) and be aware of their local NHS Stop Smoking Service and the locally agreed referral protocol.

PARTNERSHIPS WITH NON-NHS ORGANISATIONS

Commissioners are encouraged to consider the need for stop smoking services to develop and maintain partnerships with organisations outside of the NHS to aid service promotion and increase referral pathways (e.g. workplaces, children centres, the fire service).

Increasing stop smoking referrals

In contrast to other sectors of the NHS, stop smoking services are under considerable pressure to recruit smokers into treatment in order to meet challenging local targets. The seasonality of quitting behaviour by the general public can also create challenges as demand can be very high at some times of the year (e.g. January and February) yet fall to very low levels at others (e.g. July and August). Service data from previous years (including local records of referral source) may prove useful when attempting to identify referral patterns and recurring periods where service demand is low and such time could be used to plan and organise activity during periods of higher demand. However, sustained throughput of smokers will help ensure manageable levels of demand and therefore assist the consistent delivery of high-quality interventions.

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

REFERRAL SYSTEMS

Formal systems that support referrals to NHS Stop Smoking Services are needed across the health and social care sector in order to increase the number of quit attempts that benefit from expert support. Primary care teams, for example, have a key role to play in raising the issue of smoking with their patients, endorsing the value of quitting and referring them to NHS Stop Smoking Services. Currently Quality and Outcomes Framework (QOF) payments are made for recording the following:

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**Smoking Indicator 3:** The percentage of patients with any or any combination of the following conditions whose notes record smoking status in the previous 15 months – CHD, stroke/TIA, hypertension, diabetes, chronic obstructive pulmonary disease (COPD), CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses.

**Smoking Indicator 4:** The percentage of patients with any or any combination of the above conditions whose notes record that smoking cessation advice or referral to a specialist service has been offered within the previous 15 months.

**Records 23:** The percentage of patients over 15 years whose notes record smoking status in the past 27 months.

QOF indicators for smoking are due to be reviewed by NICE at the end of 2009 and the Department of Health (DH) submitted a response to support this review in October 2009.

To further assist the delivery of smoking-related activity in GP practices, a review of smoking-related read codes was undertaken by the DH tobacco team last year. From this review gaps were identified and a request for new codes was submitted, which has since been accepted. Using these codes a brief intervention pathway has been created for use in GP practices, which will be made available in 2010.

A systematic approach to increasing primary care referral rates, called Stop Smoking Interventions in Primary Care: a systems-based approach, has shown promise in some areas. Combining a tiered approach to stop smoking support with effective delivery systems within a practice, this system is being rolled out nationally by DH throughout 2009/10. The launch included a series of regional training events for NHS Stop Smoking Services and the publication of support resources for use in local practices. Evaluation of the approach is ongoing with variable levels of implementation across the country.

In 2008 Lord Darzi published High Quality Care for All, which included a commitment to make a proportion of providers’ income conditional on quality improvement and innovation through the Commissioning for Quality and Innovation (CQUIN) payment framework. This framework is intended to ensure contracts with providers include clear and agreed plans for achieving higher levels of quality by allowing PCTs to link a specific modest proportion of providers’ contract income to the achievement of ambitious locally agreed goals. Many areas have identified provider CQUIN schemes as an opportunity to include increased referral rates into local NHS Stop Smoking Services within acute contracts.

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

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NHS HEALTH CHECKS

PCTs began phased implementation of the NHS Health Check programme in April 2009. It is a universal and systematic programme for everyone between the ages of 40 and 74 that will assess people’s risk of heart disease, stroke, kidney disease and diabetes and will support people to reduce or manage that risk through individually tailored advice. Those who have been diagnosed with one of these diseases will not be eligible for a check. DH modelling work shows that offering these checks to everybody aged between 40 and 74, with recall every five years, will be both clinically beneficial and cost-effective. The programme also has the potential to reduce health inequalities. Everyone will receive a personal assessment, setting out the person’s level of risk and exactly what they can do to reduce it. For those at low risk, this might be no more than general advice on how best to stay healthy. Others may be assisted to join a weight management programme or offered an NHS Stop Smoking Service. Those at the highest risk might also require preventive medication with statins or blood pressure treatment. For a simple toolkit which enables PCTs to estimate the number of interventions that will be generated by the checks visit www.improvement.nhs.uk/NHSHealthCheck.

NHS SMOKING HELPLINE

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

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

Two pilot projects were undertaken, in the West Midlands and the South West. One involved a direct link between the NHS Smoking Helpline and the local services database; the other allowed services to access referrals from the national helpline via an online tool. Both pilots have now finished and the results are currently being reviewed. If found to be successful, the IT specifications will be circulated, enabling other PCTs to make similar connections.

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

There is a worldwide evidence base showing that effective mass-media campaigns prompt quit attempts and reduce prevalence. DH invests significantly in marketing and communications that target R/M smokers, reinforcing their motivation to quit and driving them into the most effective methods of doing so (i.e. NHS Stop Smoking Services). This strategy is based on social marketing principles (including qualitative research with the target audience and a review of behaviour change literature). The year-round campaigns use the NHS and Smokefree brands, which are being established as the recognised brands for NHS Stop Smoking Services in England.

In the same way, strategies for promoting local services should be supported by detailed research and based on local intelligence wherever possible. Extensive research exists at a national level (e.g. on R/M and other audiences) which can be shared upon request with local services to avoid duplication of resources. Information can also be provided on cost per response benchmarks and optimum mix media. Integration with regional and national campaigns should enhance their effectiveness, so they should also be planned in co-operation with tobacco control and communications colleagues from PCTs and LAs, as well as with regional tobacco control communication managers. For example, local media channels often cover large geographical areas, so planning with neighbouring PCTs could also help to create cost savings. Effective working between national, regional and local teams is also essential to ensure a seamless customer journey using the services, i.e. prompt transfer and follow-up of leads generated from marketing activity.

Local marketing initiatives can add most value by:

- Increasing the % of quit prospects considering/using their local NHS Stop Smoking Service
- Improving consumer understanding of what their local service can offer and where help is available locally
- Generating local quit prospects for local services to help deliver against 2010 targets.

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

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

Smokefree literature and other resources can be ordered from the Smokefree Resource Centre (www.smokefree.nhs.uk/resources). This also includes templates for local use which are easy to customise, and information about the national campaigns. To support the communications strategy, regions have been given funds to enable integration of the national strategy at a regional level and co-ordination of locally funded communications.
Where in post, your Regional Communications Manager will also be able to advise on best practice and share insight from national campaign activity.

**Principles for quality stop smoking interventions**

**FINANCIAL PRACTICE**

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

- When setting up SLAs with third party providers, procedures and data processing instructions (including deadlines for data submission) should be verified with providers both verbally and in writing. It should also be made clear that deviation from specifications laid out in the SLA is not permitted.

- Commissioners should refer to local NHS Standing Financial Instructions for guidance on procurement and contracting of services. In addition, commissioners should seek guidance from their local procurement team/expert to ensure they adopt a consistent approach to contracting arrangements.

- Third party providers should be required to keep all relevant records for a minimum of two years, to allow for possible auditing.

- SLAs and local enhanced service contracts should stipulate that providers may not subcontract service provision to other parties and that claims made on this basis will not be paid.

- To safeguard commissioners against the possibility of fraudulent payment claims, all claim forms submitted to the service by third party providers should include the following declaration, which should be signed and dated by the claimant:

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

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

**PRINCIPLES FOR QUALITY STOP SMOKING INTERVENTIONS**

NICE programme guidance on smoking cessation recommends the following stop smoking interventions as being cost effective:
brief interventions (see page 36)
individual behavioural counselling (see pages 38 and 39)
group behaviour therapy (see page 39)
pharmacotherapies – NRT, Zyban (bupropion) and Champix (varenicline) (see pages 50 to 59)
self-help materials
telephone counselling and helplines (see pages 40 and 41).

Services will vary in the types of intervention they choose to provide and in their approaches to delivery. The quality of these services should, of course, remain consistent and should be maintained by laying out a set of clear principles. The quality principles presented here have been developed in response to the previous CQC concerns regarding data quality and aim to improve consistency across the NHS Stop Smoking Service network. They are based on previous guidance, changes in the evidence base and the latest understanding of ‘best practice’. A complete list of adviser competences has been developed by the NHS Centre for Smoking Cessation and Training (NCSCT) and will be made available on the Centre’s website www.ncsct.co.uk.

All behavioural support 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. (NCSCT is developing an example treatment manual which will be available on the Centre’s website www.ncsct.co.uk).

Details of the behavioural support programme should be communicated to clients, and clients must commit to them.

All interventions should be multi-sessional with a total potential client contact time of at least 1.5 hours (from pre-quit preparation to four weeks after quitting). This will ensure effective monitoring, client compliance and ongoing access to medication.

There should be a strong emphasis on verifying CO levels four weeks from the quit date. This should be carried out in at least 85% of cases.

Interventions should offer weekly support for at least the first four weeks following the quit date. Appointments should be scheduled when clients are booked into treatment.

All staff involved in delivery should have been trained to Health Development Agency (HDA) standards.27 Note: from 1 April 2010, the NCSCT national training standards will supersede the HDA standard as the official benchmark of quality training for stop smoking service personnel in England. The standards will be available to all at www.ncsct.co.uk.

Stop smoking advisers should show empathy for their clients and adopt a motivational approach.

Prior to treatment, clients should be informed of all available (evidence-based) treatment options both locally and nationally.

Interventions should be efficiently managed with sufficient administrative support for general organisation, client contact processes and data handling. There should be sufficient administrative support to ensure clients are contacted within a week of being made known to the NHS Stop Smoking Service and seen within two weeks.

New, non-evidence-based delivery models (such as rolling groups or drop-ins) may be piloted on a small scale and should be carefully evaluated before being adopted as a significant part of the service.

Staff delivering rolling groups or drop-ins should be trained to HDA standards (see previous reference to HDA) and such interventions should be delivered or supervised by experienced specialists with sufficient expertise to support quitters at different stages of the quitting process simultaneously.

Only methods recommended by NICE should be funded by PCTs.

Interventions should be based on the current evidence base.

Workplace interventions should follow principles laid down in NICE workplace guidance and should be free for employees.

The Roles of Service Providers and Commissioners

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

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

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Checklist for commissioners

STRATEGIC PLANNING
Assessing needs, reviewing service provisions and deciding priorities.

1. Are you clear about the scale of the challenge to meet 2010 targets (local, regional and national indicators) and is service take-up by R/M smokers proportional to your local smoking population?

2. Have you established the composition of your local R/M population and its service needs and is NHS Stop Smoking Service development informed by local intelligence, community engagement and customer evaluation involving different populations?

3. Have you obtained local prevalence and current activity data on smoking populations? Have services been weighted in terms of deprivation and does this include high-risk groups such as those in prison or with mental health problems, as well as other priority populations such as BME groups and pregnant women?

PROCURING SERVICES
Designing services, shaping structure of supply, planning capacity and managing demand.

1. Have you sought advice and guidance from internal, local and regional networks, and are commissioners and service providers in regular communication with external sources of support (e.g. national support team, regional tobacco policy manager, regional performance leads, public health observatories, relevant academic departments and public health experts)?

2. Is the core NHS Stop Smoking Service fully aware of all commissioning arrangements for stop smoking provision and of how it should be working with other local providers of stop smoking support? (In other words, are locally commissioned stop smoking services fully integrated?)

3. Does your NHS Stop Smoking Service have a clear treatment protocol and provide weekly support?

4. Does the NHS Stop Smoking Service have at least one suitably qualified dedicated service lead?

5. Have you considered whether your NHS Stop Smoking Service offers the optimum balance of high-efficacy treatment, reach and accessibility?

6. Does your NHS Stop Smoking Service currently deliver a range of evidence-based interventions that consistently achieve auditable success rates of between 35% and 70% and comply with the quality principles? If not, what action have you planned to address this issue?

7. Are all stop smoking advisers trained to HDA standards and supported to attend regional and national training events and do they all have continuing professional development plans? Note: from 1 April 2010, the NCSCT national training standards
will supersede the HDA standard as the official benchmark of quality training for stop smoking service personnel in England. The standards will be available to all at www.ncsct.co.uk.

8. Are all NICE-approved stop smoking medicines available as first-line for treatments for smokers wanting to quit? If not, what plans are in place to address this issue?

9. Does your NHS Stop Smoking Service achieve CO validation rates at the recommended minimum of 85% of all self-reported four-week quitters? If not, what action have you planned to address this issue?

10. Does your NHS Stop Smoking Service benefit from a robust, integrated IT system that provides:
   - systems for prompt and accurate return of quarterly service data?
   - concordance with mandatory data requirements and the flexibility to update data fields when necessary?
   - the facility to manage client appointments efficiently and conduct detailed analyses of local performance?
   - the ability to analyse service performance and identify gaps in support provision?

11. Does your NHS Stop Smoking Service budget include adequate provision for the supply and maintenance of the required equipment (e.g. CO monitors, tubes, calibration kits)?

12. Have you budgeted sufficiently for local marketing and service promotion? Do local promotions use national Smokefree branding and campaign messaging and are they integrated with regional and national marketing plans?

13. Have you considered including the implementation of DH national pilots, e.g. stop smoking interventions, in primary and secondary care in provider contracts?

14. Does your NHS Stop Smoking Service have a contingency plan to deal with potential service disruption, e.g. swine flu?

15. Is the delivery of brief intervention and referral of smokers into NHS Stop Smoking Services contracted as part of other commissioned services (e.g. primary care, secondary care, mental health, health visiting, school nursing and maternity services)? Are there clear service agreements, lines of accountability and performance management arrangements in place to support delivery?

16. Does your service offer training to the above workforces on smoking cessation?

MONITORING AND EVALUATION
Seeking public and patient views, managing performance and supporting patient choice.

1. Do you have access to the full range of data required and is there effective data sharing across all providers to provide quality assurance?
2. Do you have robust and routine performance management and clinical governance systems to monitor service quality and facilitate independent audits?

3. Do you have systems in place for clinical governance, monitoring and quality assurance of third party service providers (e.g. pharmacies, GP practices, third sector and commercial providers)?

4. Do you have systems in place to measure service user satisfaction?

**Checklist for providers**

**COMMUNICATION**

1. Are you in regular communication with external sources of support (e.g. national support team, RTPM, regional performance leads, public health observatories, relevant academic departments and public health experts)?

2. Are you fully aware of all commissioning arrangements for stop smoking provision and are you following agreed protocols regarding working with other local providers of stop smoking support?

**DELIVERY**

1. Is the service’s treatment protocol being adhered to?

2. Do you currently deliver a range of evidence-based interventions that consistently achieve auditable success rates of between 35% and 70% and comply with the quality principles? If not, what action have you planned with commissioners to address this issue?

3. Are all stop smoking advisers trained to HDA standards and supported to attend regional and national training events and do they all have continuing professional development plans including regular training updates? Note: from 1 April 2010, the NCSCT national training standards will supersede the HDA standard as the official benchmark of quality training for stop smoking service personnel in England. The standards will be available to all at www.ncsct.co.uk.

4. Are all NICE-approved stop smoking medicines available as first-line for treatments for smokers wanting to quit? If not, are commissioners aware of this issue and what action is planned to address it?

5. Are a minimum of 85% of self-reported four-week quitters CO validated? If not, is the commissioner aware and what action have you planned to address this issue?

6. Do you have sufficient levels of the required equipment, e.g. CO monitors, to adhere to the quality principles (see page 26)?

7. Are you using the agreed IT system and only inputting data for treated smokers in line with quarterly data monitoring guidelines (see page 97)?

8. Are you implementing DH national pilots, e.g. stop smoking interventions, in primary and secondary care as agreed with the commissioner?
9. Do all pilot projects include an evaluation strategy and, if not, what action will you take to address this?

10. Do you offer training to other services commissioned to deliver brief interventions and referral of smokers to your service (e.g. primary care, secondary care, mental health, health visiting, school nursing and maternity services)? Are communication links being maintained?

11. Are contingency plans regularly reviewed to ensure minimal service disruption, e.g. due to swine flu?

**DATA COLLECTION AND INFORMATION SHARING**

1. Are you feeding into agreed protocols regarding sharing information across providers and to the commissioner?

2. Are detailed reports of all activity systematically being kept in case of independent audit and is client data being treated in line with agreed data protection protocols?

3. Is referral source data recorded to measure brief intervention and referral activity from other commissioned services (e.g. primary care, secondary care, mental health, health visiting, school nursing and maternity services)?

4. Is data regarding referrals generated from local marketing and service promotion activity routinely recorded to assist evaluation?

5. Are you implementing agreed systems to measure service user satisfaction?

**MANAGEMENT OF OTHER PROVIDERS**

Where providers are responsible for the management of LES/SLA providers, have systems been agreed with the commissioner to ensure such providers are also adhering to the points in this checklist?

**WORLD CLASS COMMISSIONING**

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

**WORLD CLASS STOP SMOKING SERVICES**

This updated guidance will be useful for PCTs that have selected smoking prevalence as a WCC priority (see below). It will help them identify what quality smoking cessation services look like, enabling them to select services based on the best available evidence and plan realistically to improve their current services.
In essence, WCC consists of 11 commissioning competences, an assessment of organisational governance and of performance against local health outcomes. The WCC competences describe a full commissioning cycle, from strategic planning (including engagement and partnership working) to robust technical skills such as needs assessment, information analysis, market shaping, contracting and procurement. They depend on tight performance management and management of finances. Developing strengths in all of these competences will improve outcomes, reduce health inequalities and, ultimately, ‘add life to years, and years to life’ – and that means better care and better value.

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

**Strategic planning**

In 2008, all 152 PCTs were charged with producing five-year plans outlining how they would deliver their local health priorities. Strategic planning to achieve improved health outcomes is at the core of the business of the PCT and, as a result, at the core of WCC assurance. For the purpose of WCC assurance, strategic plans will be underpinned by a five-year financial plan and an organisational development plan. In response to the current economic climate, PCTs will need to ensure that their plans allow for three financial scenarios. Further guidance and templates to support PCTs in strategic plan development are available at [www.wccassurance.dh.gov.uk](http://www.wccassurance.dh.gov.uk).

As part of the WCC commissioning assurance system, and to demonstrate skills in prioritising and strategic planning, all PCTs have set out in their strategic plans up to 10 local health outcomes against which they will be assessed as part of assurance of commissioning capability.
This process does not cut across the performance role in delivering against the wider set of national existing commitments and making progress against the indicators in the Vital Signs. All PCTs are still required to meet these commitments. The outcomes element of the commissioning assurance system assesses PCTs on their ability to reflect the strategic priorities of their partners and local populations and to deliver improvements in health and well-being for their populations.

Two of these 10 local outcomes are nationally set (life expectancy and health inequality) and the others are for selection locally in line with the five-year strategic plan being developed by every PCT with its partners. Smoking cessation was the health outcome most frequently selected by PCTs in 2008/09. In 2009/10 PCTs are setting local aspirations for improvement and delivery against the long-term priority health outcomes in their strategic plans.

**World Class Commissioning support and development**

To help them become world class commissioners, PCTs can draw upon a range of resources they can tailor to their local needs. Support material is being developed by SHAs, while DH has established a framework of providers of board development who can help PCTs strengthen their governance arrangements. Other national resources are available via the WCC support and development website [www.networks.nhs.uk](http://www.networks.nhs.uk).
Evidence has shown that a combination of behavioural support from a stop smoking adviser plus pharmacotherapy (see page 50) can increase a smoker’s chances of stopping by up to four times. Stop smoking support can be delivered in a number of ways and it is important that smokers are offered a range of support options so they can choose the type of intervention that is right for them. All interventions share common properties (such as behavioural support, structure and the offer of approved pharmacotherapy) and they all involve multiple sessions.

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

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

The following pages contain pragmatic definitions of the intervention types described in the quarterly dataset. They are not meant to constrain practitioners but reflect current delivery methods and the language used to describe the services being delivered at a local level. All figures quoted are from the NHS Information Centre (IC) April 2008 to March 2009 experimental statistics. They can be accessed via the website www.ic.nhs.uk.  

EVIDENCE RATING OF RECOMMENDATIONS

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

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

Brief and very brief interventions

Evidence rating: A

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

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

GUIDANCE FOR HEALTHCARE PROFESSIONALS

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

Since giving stop smoking advice need only take a few minutes, all HCPs should be encouraged to systematically deliver very brief or brief interventions to all smokers at every opportunity.

Example script
‘In this [setting: i.e. practice or pharmacy] it is our policy to offer every smoker a referral to our local NHS Stop Smoking Service, which can offer you your best chance of stopping. Are you happy for me to do that for you now?’

THE ROLE OF NHS STOP SMOKING SERVICES

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

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

- ** tiered stop smoking support** that establishes several levels of intervention. For example: 30-second very brief confidence-boosting advice for all smokers and referral to NHS Stop Smoking Services (see the diagram on page 38); more detailed intervention if there is time; and intensive support for highly motivated patients or those at high risk of developing smoking-related diseases

- **a 10-part supportive delivery system** that offers high-quality stop smoking support to patients who attend in a practice setting

- **a supportive practice environment** with friendly advice and promotional materials to help patients stop smoking, and where smokefree is the norm

- **helpful checklists and templates** to assess current systems, set an agenda for change and reward performance.
Figure 2: Very brief advice – 30 seconds to save a life

VERY BRIEF ADVICE (AAA)
– 30 seconds to save a life

1. **ASK and record smoking status**
   Smoker – ex-smoker – non-smoker

2. **ADVISE patient of health benefits**
   Stopping smoking is the best thing you can do for your health

3. **ACT on patient’s response**
   Build confidence, give information, refer, prescribe
   Succeed with local NHS Stop Smoking Services

Refer your patients to the local NHS Stop Smoking Service and give them the best chance to quit and improve their health – they are up to four times more likely to quit successfully with NHS support.

Brief advice and intervention is more effective when part of an overall stop smoking strategy within your practice. Your local NHS Stop Smoking Service can help develop and maintain a successful strategy, including auditing referrals and Quality and Outcomes Framework (QOF) payments.

**Behavioural support**

**Evidence rating:** A

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

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

ONE-TO-ONE SUPPORT

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

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

The average self-reported quit rate in England for one-to-one, face-to-face support is 49% (n = 260,162), contributing 77.2% of the total number of successful self-reported four-week quitters in 2008/09.

COUPLE/FAMILY SUPPORT

Evidence rating: I

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

The average self-reported quit rate in England for couple and family support is 55% (n = 2,641), contributing 0.8% of the total number of successful self-reported four-week quitters in 2008/09.

CLOSED GROUP SUPPORT

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

A face-to-face intervention facilitated by one or more stop smoking advisers, with a number of smokers at a specified time and place. For example, a group may be held once a week over a specific number of weeks, e.g. every Tuesday evening from 7.00pm to 8.00pm for six to seven weeks (see Quality principles on page 26 for the minimum recommended client contact time). To account for diminishing client returns, a minimum of eight members is recommended.

The average self-reported quit rate in England for closed group support is 64% (n = 11,553), contributing 3.4% of the total number of successful self-reported four-week quitters in 2008/09.

OPEN (ROLLING) GROUP SUPPORT

Evidence rating: I

A face-to-face intervention facilitated by one or more stop smoking advisers, with a number of smokers at a specified time and place.

The average self-reported quit rate in England for open (rolling) group support is 55% (n = 17,154), contributing 5.1% of the total number of successful self-reported four-week quitters in 2008/09.
DROP-IN SUPPORT

*Evidence rating: [I]*

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

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

The average self-reported quit rate in England for drop-in support is 49% (n = 31,596), contributing 9.5% of the total number of successful self-reported four-week quitters in 2008/09.

TELEPHONE SUPPORT

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

Proactive telephone support

*Evidence rating: [A]*

*Estimated success rate range: 22%–51%

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

The average self-reported quit rate in England for telephone support is 63% (n = 4,380), contributing 1.3% of the total number of successful self-reported four-week quitters in 2008/09.

All proactive telephone interventions should have a total potential contact time with the client of a minimum of 1.5 hours (from pre-quit preparation to the four-week post-quit period). This is to ensure regular monitoring, client compliance and continual access to pharmacotherapy. A minimum of 10 interventions in a 12-week period is recommended, with a minimum of 10 minutes per intervention, apart from the first session which will need to be longer to allow for assessment and planning.

Reactive telephone support

*Evidence rating: [B]*

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

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Text-based telephone support

Evidence rating: B

A recent Cochrane review into mobile phone-based interventions for smoking cessation concluded that the current evidence shows no effect of such interventions on long-term outcome. While 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.35

NHS SMOKING HELPLINE TRIAL

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

Called the Proactive or Reactive Telephone Smoking Cessation Support (PORTSSS) trial, the 18-month study involves academics at Nottingham, Bath, Glasgow and University College London universities and began in early 2009. The trial is looking at whether the telephone helpline’s success rate could be improved by using scheduled calls to deliver support similar to that provided in face-to-face interventions, and by mailing participants vouchers for nicotine patches. Recruitment to the trial is nearly complete but results are not expected before autumn 2010.

ONLINE SUPPORT

Evidence rating: B

Estimated success rate range: 28%–66%

A rapid review of the evidence in this area concluded that online support for smoking cessation can be acceptable to users and is of superior efficacy to other wide-reach interventions and of similar efficacy to face-to-face interventions.36

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

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

Figure 3: Intervention pathways

Is the main intervention delivered face to face?

No

Is the intervention provided by a stop smoking adviser over the phone?

No

Is the intervention web-based?

Yes

Online support

Proactive telephone support

How many people are involved in the intervention (including the stop smoking adviser)?

More than 2 people

2 people

Are the clients related or friends?

No

Does the group meet for a specific number of weeks only?

No

Open group support

Yes

Closed group support

Yes

Are a specific appointment time given?

No

How many people are involved in the intervention (including the stop smoking adviser)?

8+

3–7

Couple/family support

Yes

Online support

Proactive telephone support

Is the intervention web-based?

Yes

Online support

Proactive telephone support

Does the group meet for a specific number of weeks only?

No

Open group support

Yes

Closed group support

Evidence rating A

Evidence rating B

Evidence rating C

Evidence rating D
Assessing nicotine dependence

QUANTITATIVE APPROACH

Evidence rating: A

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

THE FAGERSTRÖM TEST FOR NICOTINE DEPENDENCE

1. How soon after you wake up do you smoke your first cigarette?
   - After 60 minutes (0)
   - 31–60 minutes (1)
   - 6–30 minutes (2)
   - Within 5 minutes (3)

2. Do you find it difficult to refrain from smoking in places where it is forbidden?
   - No (0)
   - Yes (1)

3. Which cigarette would you hate most to give up?
   - The first in the morning (1)
   - Any other (0)

4. How many cigarettes per day do you smoke?
   - 10 or fewer (0)
   - 11–20 (1)
   - 21–30 (2)
   - 31 or more (3)

5. Do you smoke more frequently during the first hours after waking than during the rest of the day?
   - No (0)
   - Yes (1)

6. Do you smoke even if you are so ill that you are in bed most of the day?
   - No (0)
   - Yes (1)

Your score was: ________________

Your level of dependence on nicotine is:

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

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HEAVINESS OF SMOKING INDEX

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

SHORTENED FTND

1. How soon after you wake do you smoke your first cigarette? (circle one response)
   - Within 5 minutes 3
   - 6–30 minutes 2
   - 31–60 minutes 1
   - After 60 minutes 0

2. How many cigarettes per day do you usually smoke?
   - 10 or fewer 0
   - 11–20 1
   - 21–30 2
   - 31 or more 3

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

OBJECTIVE APPROACH

Objective biochemical validation methods such as cotinine assessment can also be used to assess nicotine dependency by measuring the quantity of nicotine metabolites present. CO testing measures smoke intake and provides an immediate and cheaper alternative to cotinine testing (see page 50).

Biochemical markers

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

CARBON MONOXIDE

Evidence rating: A

As self-reported smoking status can be unreliable, CO verification rates are an important marker of data quality. CO testing should be carried out on all adult smokers, wherever possible, to provide both a baseline (pre-quit) level and a four-week validation (post-quit) level. CO testing is quick to carry out, non-invasive and provides a cost-effective means of validating the smoking status of a significant number of clients.
There is considerable anecdotal evidence that suggests that CO testing can be highly motivating for clients, as their readings decrease over a relatively short period if they quit successfully. When introducing the CO monitor to clients, they should be made aware of its motivational benefits and given an explanation as to what it can and cannot measure. To achieve as accurate a reading as possible, clients should be asked to hold their breath for 20 seconds (15 seconds minimum) before blowing into the CO monitor.

Some clients may not be able to physically complete CO testing due to the inability to hold their breath for 15 or more seconds. It is expected that a minimum of 85% of self-reported four-week quitters undertake expired CO validation. NHS Stop Smoking data from 2008/09 indicates that on average services are achieving CO validation rates of around 67%, so there is some way to go towards achieving recommended levels.38

**THE PERCENTAGE OF CO-VERIFIED CLIENTS FROM ALL QUIT DATES SET CAN BE CALCULATED AS FOLLOWS:**

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

All treated smokers

Numeric example:

<table>
<thead>
<tr>
<th>Treated smokers</th>
<th>Self-reported 4-week quitters</th>
<th>No. of self-reported 4-week quitters CO-verified</th>
<th>% of all treated smokers CO-verified</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>50</td>
<td>35</td>
<td>35/100 = 35%</td>
</tr>
</tbody>
</table>

**THE PERCENTAGE OF SELF-REPORTED FOUR-WEEK QUITTERS WHO HAVE BEEN CO-VERIFIED CAN BE CALCULATED AS FOLLOWS:**

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

All self-reported four-week quitters

Numeric example:

<table>
<thead>
<tr>
<th>Treated smokers</th>
<th>Self-reported 4-week quitters</th>
<th>No. of self-reported 4-week quitters CO-verified</th>
<th>% of all treated smokers CO-verified</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>50</td>
<td>35</td>
<td>35/50 = 70%</td>
</tr>
</tbody>
</table>

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Monitoring carbon monoxide levels effectively
A recent survey of CO verification within NHS Stop Smoking Services showed that provision varies greatly. As a result, it made the following recommendations:

- All stop smoking advisers need to have access to a CO monitor at every consultation. This should be supplied and properly maintained by the NHS Stop Smoking Service. Systems should be in place to ensure that CO monitors are calibrated according to the manufacturer’s instructions.

- Stop smoking service training and documentation should stress the different uses of CO measurement at different time points, and emphasise the importance of verifying levels at the four-week post-quit point.

- Stop smoking services should have a written protocol for CO monitoring. This protocol should emphasise the importance of obtaining CO verification of self-reports as part of follow-up procedures. There will also need to be a written protocol detailing infection control and management issues. The protocol should clearly state when monitors need calibrating, who should do it and how it should be done.

- Payment should only be made to intermediate advisers under a Local Enhanced Service (LES) if a full monitoring form (see Annex H) is completed and submitted to the stop smoking service. The stipulation that follow-up at four weeks is to be conducted with all self-reported quitters should be written into the LES agreement. If clients do not attend their appointment, they should be followed up by telephone, text or email (three times at different times of day) and, importantly, asked and encouraged to attend for CO verification.

- Regional variations need to be addressed by ensuring that the regional tobacco control team monitors the data on CO verification from NHS Stop Smoking Services within its region and attends to low-performing services.

SWINE FLU AND INFECTION CONTROL GUIDANCE
Guidance for all who conduct lung age tests and CO tests as part of their activities within the NHS has recently been updated and can be accessed at www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_104398.pdf

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SAMPLE CARBON MONOXIDE MONITOR PROTOCOL (INFECTION CONTROL)

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

Plastic adaptor/T-piece
The adaptor contains a one-way valve that prevents inhalation from the monitor. Changing adaptors depends on manufacturers’ guidance:

- **Micromedical**: the adaptor should be discarded and replaced every six months
- **Bedfont (piCO)**: the adaptor should be discarded and replaced monthly
- **BMC-2000**: the adaptor should be changed quarterly, unless usage is heavy, in which case change monthly

**Usage guidance**

- Less than 50 uses per month: change quarterly
- Between 51 and 200 uses per month: change bi-monthly
- More than 200 uses per month: change monthly

Contact your nearest NHS Stop Smoking Service office for supplies of adaptors/T-pieces.

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

**Calibrating**
All monitors should be calibrated every six months. Contact your nearest NHS Stop Smoking Service office to arrange calibration.

**NHS Stop Smoking Services offices**
[Insert service details here]

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

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

Health and Safety Executive (HSE) research from 2006\(^40\) suggested that low-level chronic CO poisoning is a potential issue, with 8% living with dangerous levels of CO (CO is thought to kill 50 people each year and injure about 200).

\(^{40}\) Health and Safety Executive (2006) Review of Domestic Gas Safety. HSE
The most common symptoms of mild CO poisoning are:

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

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

Expired breath CO monitors have been validated to detect oxyhaemoglobin levels in non-smokers, and can therefore be used for purposes other than validation of smoking status.41,42

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

**LUNG HEALTH AND CHRONIC OBSTRUCTIVE PULMONARY DISEASE**

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

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

If people do smoke, then stopping is the single most effective, and cost-effective, way of reducing the risk of getting COPD. Stopping smoking can prevent or delay the development of airflow limitation, or reduce its progression,43 and can have a substantial effect on subsequent mortality.44

Given the prevalence data on COPD in smoking populations, between 25% and 40% of the 300,000 people who access NHS Stop Smoking Services already have early COPD. However, the current system does not require a brief forced expiration screen/lung age measure to be taken. DH’s national COPD Clinical Strategy requires a more effective way of identifying people with COPD early – and up to 130,000 of the unidentified 2 million people with COPD every year could be found using current NHS Stop Smoking Services. This represents a cost-effective use of existing resources, making it unnecessary to develop additional new processes.
Addressing chronic obstructive pulmonary disease during treatment
Since most smokers are not aware of the symptoms of COPD, it is recommended that all NHS Stop Smoking Service clients are informed of the following:

- that 80% of COPD is caused by smoking
- the key symptoms, which are:
  - chronic cough
  - breathlessness
  - production of spit or sputum after a coughing fit
- the best options for advice/assessment if they have symptoms and are concerned.

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

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

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

**Chronic Obstructive Pulmonary Disease Clinical Strategy**
The forthcoming COPD Clinical Strategy is expected in May 2010 and will contain the following recommendations that relate to NHS stop smoking services and that should be noted:

- People at risk of developing a respiratory condition understand the consequences of exposure to the main causal factors.
- Smoking cessation programmes explore the use of a lung age test and/or include screening for lung disease.

This strategy relies on the notion that interventions should seek to establish a connection between inhalational exposure and poor lung health. There are two ways in which air pollutants cause ill health or death: day-to-day variations in inhalational exposure, causing day-to-day increases in illness and mortality; and long-term inhalational exposures that cause disease in previously disease-free individuals.

As mentioned earlier, the greatest risk to lung health is posed by smoking, accounting for nearly 80% of the total number of people with COPD. Other factors include workplace exposure and general environmental pollution.

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

Formula for measuring an individual’s lung age:45

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

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

INCREASING QUIT RATES THROUGH LUNG FUNCTION/SPIROMETRY

Evidence rating: 1

A Cochrane review concluded that there is a lack of evidence to support these approaches as methods for increasing quit rates. Despite the lack of data and the heterogeneity of the trials, the authors concluded that: ‘Current evidence of lower quality does not, however, support the hypothesis that biomedical risk assessment increases smoking cessation in comparison with standard treatment.’46

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

COTININE

Evidence rating: A

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

Pharmacotherapy

Combining behavioural support with pharmacotherapy increases a smoker’s chances of successfully stopping by up to four times.47 The only stop smoking medications currently approved by NICE are nicotine replacement therapy (NRT), bupropion (Zyban) and varenicline (Champix).

Primary care trust (PCT) leads and local prescribing committees should note that medicines recommended by NICE are extremely cost-effective and that cost-effectiveness studies are published on the NICE website. The numbers needed to treat (NNTs) in order to achieve a long-term quitter compare very favourably with other interventions routinely delivered in primary care. Therefore, all current and any new NICE-recommended products should be made available to smokers as soon as possible.

Current experimental statistics from NHS Stop Smoking Services indicate that varenicline was the most successful smoking cessation aid between April 2008 and March 2009. Of those who used varenicline, 61% successfully quit, compared with 51% who received bupropion only, and 48% who received NRT.\(^{48}\)

**BEST PRACTICE POINTS**

- All stop smoking pharmacotherapies should be offered on prescription to any smoker who is motivated to quit. Many areas use patient group directions (PGDs) and/or voucher systems to make this possible.
- All pharmacotherapies should remain available for at least the duration recommended by the product specification (see Table 6 on page 53) and patients should be able to access approved stop smoking medicines simply and easily.
- Pharmacotherapies should be available for more than one treatment episode. For example: if a client using Champix relapses during a quit attempt, providing they are adequately motivated to attempt to stop again (see Time between treatment episodes on page 97) they should be able to begin a new course of Champix if this is assessed to be the most appropriate medicine for that client.
- Where a client relapses during a quit attempt and does not wish to begin a new treatment episode (see Treatment episode on page 97), no further pharmacotherapy should be provided until such time when the client is motivated to make another quit attempt.
- In the case of NRT, local prescribing arrangements should consider the need to balance the total number and cost of prescription charges incurred by the client and the need for structured and frequent face-to-face contact.
- The relative impact of evidence-based stop smoking interventions and pharmacotherapies on four-week quit rates is shown on page 14 of this document.

### EXPERIMENTAL STATISTICS

#### Table 5: Number setting a quit date and successful quitters, by type of pharmacotherapy received, April 2008 to March 2009

**England numbers/percentages**

<table>
<thead>
<tr>
<th>Numbers</th>
<th>Number setting a quit date</th>
<th>Number of successful quitters</th>
<th>Percentage who quit successfully</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numbers</strong></td>
<td>671,259</td>
<td>337,054</td>
<td>50</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number who received NRT only</td>
<td>449,876</td>
<td>214,873</td>
<td>48</td>
</tr>
<tr>
<td>Number who received bupropion (Zyban) only</td>
<td>11,278</td>
<td>5,732</td>
<td>51</td>
</tr>
<tr>
<td>Number who received varenicline (Champix) only</td>
<td>134,949</td>
<td>82,646</td>
<td>61</td>
</tr>
<tr>
<td>Number who received both NRT and bupropion (Zyban)</td>
<td>1,022</td>
<td>493</td>
<td>48</td>
</tr>
<tr>
<td>Number who received both NRT and varenicline (Champix)</td>
<td>5,915</td>
<td>2,948</td>
<td>50</td>
</tr>
<tr>
<td>Number who did not receive any pharmacotherapies</td>
<td>35,774</td>
<td>17,270</td>
<td>48</td>
</tr>
<tr>
<td>Number where treatment option not known</td>
<td>32,445</td>
<td>13,092</td>
<td>40</td>
</tr>
</tbody>
</table>

| Percentages                                   |                            |                                |                                 |
|----------------------------------------------|----------------------------|                                |                                 |
| Total                                        | 100                        | 100                            | –                               |
| Number who received NRT only                 | 67                         | 64                             | –                               |
| Number who received bupropion (Zyban) only   | 2                          | 2                              | –                               |
| Number who received varenicline (Champix) only | 20                         | 25                             | –                               |
| Number who received both NRT and bupropion (Zyban) | 0                          | 0                              | –                               |
| Number who received both NRT and varenicline (Champix) | 1                          | 1                              | –                               |
| Number who did not receive any pharmacotherapies | 5                          | 5                              | –                               |
| Number where treatment option not known     | 5                          | 4                              | –                               |

*Source: adapted from Lifestyle Statistics, NHS Information Centre, 2009.*
The full summary of product characteristics (SPC) for the following products can be found on the electronic Medicines Compendium website at http://emc.medicines.org.uk.

Table 6: Product specifications

<table>
<thead>
<tr>
<th>Brand</th>
<th>Product</th>
<th>Treatment duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>NiQuitin CQ</td>
<td>24-hr patch</td>
<td>Adults (18+) 6 weeks</td>
</tr>
<tr>
<td></td>
<td>21mg</td>
<td>Adults (18+) 2 weeks</td>
</tr>
<tr>
<td></td>
<td>14mg</td>
<td>Adults (18+) 2 weeks</td>
</tr>
<tr>
<td></td>
<td>7mg</td>
<td>Adolescents (12–18) As adults</td>
</tr>
<tr>
<td></td>
<td>Lozenge</td>
<td>Adults (18+) 12 weeks</td>
</tr>
<tr>
<td></td>
<td>4mg</td>
<td>Adolescents (12–18)</td>
</tr>
<tr>
<td></td>
<td>2mg</td>
<td>12 weeks maximum</td>
</tr>
<tr>
<td></td>
<td>Minis mint lozenge</td>
<td>Adults (18+) Continue use for up to 6 weeks, then gradually reduce lozenge use. When daily use is 1–2 lozenges, use should be stopped</td>
</tr>
<tr>
<td></td>
<td>4mg</td>
<td>Adolescents (12–18)</td>
</tr>
<tr>
<td></td>
<td>1.5mg</td>
<td>12 weeks maximum</td>
</tr>
<tr>
<td></td>
<td>Gum</td>
<td>Adults (18+) Use for up to 3 months and then gradually reduce gum use. When daily use is 1–2 pieces, use should be stopped</td>
</tr>
<tr>
<td></td>
<td>4mg</td>
<td>Adolescents (12–18)</td>
</tr>
<tr>
<td></td>
<td>2mg</td>
<td>12 weeks maximum</td>
</tr>
<tr>
<td>Nicotinell</td>
<td>24-hr patch</td>
<td>Adults (18+) 3 months</td>
</tr>
<tr>
<td></td>
<td>21mg</td>
<td>Adolescents (12–18)</td>
</tr>
<tr>
<td></td>
<td>14mg</td>
<td>12 weeks maximum</td>
</tr>
<tr>
<td></td>
<td>7mg</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lozenge</td>
<td>Adults (18+) Withdraw treatment gradually after 3 months. Discontinue use when dose is reduced to 1–2 lozenges per day</td>
</tr>
<tr>
<td></td>
<td>2mg</td>
<td>Maximum period of treatment: 6 months</td>
</tr>
<tr>
<td></td>
<td>1mg</td>
<td>Adolescents (12–18)</td>
</tr>
<tr>
<td></td>
<td>Gum</td>
<td>Not to be used in under-18s without a recommendation from a physician</td>
</tr>
<tr>
<td></td>
<td>4mg</td>
<td>Adolescents (12–18)</td>
</tr>
<tr>
<td></td>
<td>2mg</td>
<td>12 weeks maximum</td>
</tr>
</tbody>
</table>

Continued overleaf >>
### Table 6: Product specifications *continued*

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

*Continued opposite*
### Table 6: Product specifications continued

<table>
<thead>
<tr>
<th>Brand</th>
<th>Product</th>
<th>Treatment duration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Microtab</strong></td>
<td>Adults (18+)</td>
<td>Gradually reduce after 3 months</td>
</tr>
<tr>
<td></td>
<td>Adolescents (12–18)</td>
<td>12 weeks maximum. Use for 8 weeks and then gradually reduce the dose over a 4-week period</td>
</tr>
<tr>
<td><strong>Pfizer</strong></td>
<td>Varenicline</td>
<td>Adults (18+)</td>
</tr>
<tr>
<td></td>
<td>(Champix)</td>
<td>12 weeks + 12 weeks – refer to NICE</td>
</tr>
<tr>
<td></td>
<td>Adolescents (12–18)</td>
<td>Contraindicated for under-18s</td>
</tr>
<tr>
<td><strong>GlaxoSmith-Kline</strong></td>
<td>Bupropion</td>
<td>Adults (18+)</td>
</tr>
<tr>
<td></td>
<td>(Zyban)</td>
<td>8–9 weeks</td>
</tr>
<tr>
<td></td>
<td>Adolescents (12–18)</td>
<td>Contraindicated for under-18s</td>
</tr>
</tbody>
</table>
FACTORS AFFECTING THE METABOLISM OF NICOTINE

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

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

<table>
<thead>
<tr>
<th>Factor</th>
<th>Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Women metabolise nicotine <strong>15%</strong> faster than men</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Pregnant women metabolise nicotine up to <strong>60%</strong> faster</td>
</tr>
<tr>
<td>Oral contraceptive</td>
<td>Women using an oral contraceptive metabolise nicotine <strong>40%</strong> faster</td>
</tr>
</tbody>
</table>

NICOTINE REPLACEMENT THERAPY

Evidence rating: **A**

NRT is safe and effective, and when used in isolation (without additional behavioural support) approximately doubles the chances of long-term abstinence.\(^{49,50}\) There are six different types of NRT: patch (24-hour and 16-hour), gum, lozenge, microtab, nasal spray and inhalator. There is no evidence to suggest that one type of NRT is more effective than another (see Table 7), so product selection should be guided by client preference.

**Table 7: Effectiveness of different forms of NRT**

<table>
<thead>
<tr>
<th>Form of NRT</th>
<th>RR</th>
<th>95% CI</th>
<th>No. of trials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any form</td>
<td>1.58</td>
<td>1.50–1.66</td>
<td>41</td>
</tr>
<tr>
<td>Nasal spray</td>
<td>2.02</td>
<td>1.49–3.73</td>
<td>53</td>
</tr>
<tr>
<td>Tablets/lozenges</td>
<td>2.00</td>
<td>1.63–2.45</td>
<td>6</td>
</tr>
<tr>
<td>Inhalers</td>
<td>1.90</td>
<td>1.36–2.67</td>
<td>4</td>
</tr>
<tr>
<td>Patches</td>
<td>1.66</td>
<td>1.53–1.81</td>
<td>41</td>
</tr>
<tr>
<td>Gum</td>
<td>1.43</td>
<td>1.33–1.53</td>
<td>53</td>
</tr>
</tbody>
</table>

RR: risk ratio of abstinence relative to control
CI: confidence interval
Source: Stead et al. (2008)\(^{51}\)

\(^{49}\) 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

\(^{50}\) 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

\(^{51}\) Ibid
Nicotine replacement therapy with special population groups
Following a review by the Medicines and Healthcare products Regulatory Agency (MHRA) in 2005, NRT can now be used by adolescents aged 12 and over, pregnant women and people with cardiovascular disease. Full details of the report can be found on the MHRA website at www.mhra.gov.uk/SearchHelp/Search/Searchresults/index.htm?within=Yes&keywords=smoking+cessation.

COMBINATION THERAPY

Evidence rating: A

A combination of NRT products (combination therapy) has been shown to have an advantage over using just one product.\textsuperscript{52,53} It is also considered cost-effective.\textsuperscript{54} NHS Stop Smoking Services should therefore routinely offer clients combination therapy whenever appropriate.\textsuperscript{55}

PRELOADING/NICOTINE-ASSISTED REDUCTION TO STOP (NARS)

Evidence rating: B

There is some evidence that using the nicotine patch for a short period before a quit attempt results in higher cessation rates.\textsuperscript{56} Using NRT while cutting down on cigarettes can be helpful for heavy smokers who find stopping in one step too difficult. Systematic reviews found that using NRT while smoking significantly increases the likelihood of long-term abstinence\textsuperscript{57} and the odds of cessation.\textsuperscript{58} However, there is insufficient evidence about the long-term benefits of interventions intended to help smokers reduce but not stop smoking.

\textsuperscript{52} 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
\textsuperscript{53} 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
\textsuperscript{55} National Institute for Health and Clinical Excellence (2008) Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities. NICE. www.nice.org.uk/Guidance/PH10/NiceGuidance/pdf/English
\textsuperscript{58} Stead L and Lancaster T (2007) ‘Interventions to reduce harm from continued tobacco use.’ Cochrane Database of Systematic Reviews, Issue 3
BUPROPION (ZYBAN)

Evidence rating: A

Bupropion is an anti-depressant medication that can almost double the chances of long-term abstinence.\(^{59}\) It is a prescription-only medication and should not be used in combination with any other stop smoking medications.\(^{60}\) There is no evidence to show whether bupropion is less or more effective than NRT, although three randomised controlled trials (RCTs) have shown it to be less effective than varenicline on long-term abstinence.\(^{61}\)

Cautions and adverse effects

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

VARENICLINE (CHAMPIX)

Evidence rating: A

A prescription-only drug, varenicline has been shown to increase the chances of long-term abstinence two- to three-fold.\(^{62}\) Three RCTs have shown it to be more effective than bupropion.\(^{63}\)

Cautions and adverse effects

A 2007 Cochrane review reported that the most common adverse effect was mild to moderate levels of nausea that subsided over time.\(^{64}\) The decision to use varenicline must depend on client preference and prior consideration of its cautions. These are listed in the SPC, which can be accessed on the electronic Medicines Compendium website at http://emc.medicines.org.uk.

---

59 Hughes JR, Stead L and Lancaster T (2007) 'Antidepressants for smoking cessation.' Cochrane Database of Systematic Reviews, Issue 1
61 Cahill K, Stead L and Lancaster T (2007) 'Nicotine receptor partial agonists for smoking cessation.' Cochrane Database of Systematic Reviews, Issue 1
62 Ibid
63 Ibid
64 Ibid
Depression, suicide ideation and suicide attempts

According to a recent paper by Stapleton (2009), UK data does not currently appear to suggest a causal link or even an association between varenicline and suicide. A recent cohort study also found no clear evidence to show that varenicline was associated with an increased risk of depression or suicidal thoughts.

The following appears within the SPC for varenicline:

Depression, suicidal ideation and behaviour and suicide attempts have been reported in patients attempting to quit smoking with Champix in the post-marketing experience. Not all patients had stopped smoking at the time of onset of symptoms and not all patients had known pre-existing psychiatric illness. Clinicians should be aware of the possible emergence of significant depressive symptomatology in patients undergoing a smoking cessation attempt, and should advise patients accordingly. Champix should be discontinued immediately if agitation, depressed mood or changes in behaviour that are of concern for the doctor, the patient, family or caregivers are observed, or if the patient develops suicidal ideation or suicidal behaviour.

Depressed mood, rarely including suicidal ideation and suicide 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).

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

WORKING WITH THE PHARMACEUTICAL INDUSTRY

In February 2008, DH published Best Practice Guidance on joint working between the NHS and pharmaceutical industry and other relevant commercial organisations. This publication shows NHS staff how to maintain the balance between partnership and ethical working. A copy is available on the DH website at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082370

65 Stapleton J (2009) ‘Do the 10 UK suicides among those taking the smoking cessation drug varenicline suggest a causal link?’ Addiction 104(5):864–5
OTHER PRODUCTS AND THEIR EVIDENCE BASE

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

### Table 8: Some evidence of effectiveness but not recommended

<table>
<thead>
<tr>
<th>Product</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rapid smoking</td>
<td>RCT evidence suggests that this can improve 6-month abstinence rates. However, due to the possible harmful effects, i.e. increased heart rate, systolic blood pressure and carboxyhaemoglobin, this intervention should not be used.(^\text{67, 68})</td>
</tr>
<tr>
<td>Cytisine</td>
<td>There are dated and limited studies which indicate that this plant alkaloid may be a useful stop smoking aid. Further research is required, however, before it can be recommended for use.(^\text{69, 70, 71, 72})</td>
</tr>
</tbody>
</table>

---

68 Hajek P and Stead LF (2006) ‘Aversive smoking for smoking cessation’. *Cochrane Database of Systematic Reviews* (2)
Table 9: Insufficient evidence – currently not recommended

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

<table>
<thead>
<tr>
<th>Intervention/product</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allen Carr</td>
<td>RCT data is required to assess true efficacy.</td>
</tr>
<tr>
<td>Nicobrevin</td>
<td>Two trials suggest a potential effect on short-term outcomes but, as both studies had problems with their methodologies, the results should be considered with caution. There is no evidence to show a long-term effect on abstinence.</td>
</tr>
<tr>
<td>NicoBloc</td>
<td>One small, well designed, randomised, double-blind placebo-controlled trial shows no benefit over the placebo.</td>
</tr>
<tr>
<td>St John's wort</td>
<td>Due to its potential antidepressant properties, some believe that St John's wort may also prove a useful aid to stopping smoking. However, two small studies suggest that a dose of 600mg per day has no effect on smoking cessation.</td>
</tr>
<tr>
<td>Glucose</td>
<td>This shows a positive effect on abstinence rates when used in combination with NRT or bupropion. Contraindicated for diabetics.</td>
</tr>
<tr>
<td>Lobeline</td>
<td>This is a plant-based partial nicotine agonist, structurally similar to nicotine. There are a number of controlled trials that report on short-term outcomes but none show the benefit of lobeline over the control.</td>
</tr>
<tr>
<td>Exercise</td>
<td>There is some evidence to suggest that exercise can have a positive effect on relieving tobacco withdrawal symptoms and short-term abstinence rates. Furthermore, exercise may increase self-esteem and assist in managing post-quit weight gain. A systematic review of 12 studies that compared exercise with a passive condition found positive effects on cigarette cravings, withdrawal symptoms and smoking behaviour. This suggests that exercise can be a useful aid to managing cigarette cravings and withdrawal symptoms.</td>
</tr>
</tbody>
</table>

82 Ussher M (2005) ‘Exercise interventions for smoking cessation.’ Cochrane Database of Systematic Reviews, Issue 1
Table 10: Evidence of no effectiveness – not recommended

<table>
<thead>
<tr>
<th>Product</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypnosis</td>
<td>Hypnosis does not improve long-term abstinence rates.84</td>
</tr>
<tr>
<td>Acupuncture, acupressure, laser therapy and electrostimulation</td>
<td>These do not improve long-term abstinence rates over the placebo effect.85,86</td>
</tr>
<tr>
<td>Anxiolytics (i.e. diazepam)</td>
<td>There is no evidence that such drugs are effective in stopping smoking.87</td>
</tr>
<tr>
<td>Incentives/competitions</td>
<td>Incentives have been shown to increase participation rates although this does not necessarily propel more people into successfully stopping smoking. Evidence shows that incentives/competitions do not increase long-term abstinence rates.88</td>
</tr>
</tbody>
</table>

NOVEL NICOTINE DELIVERY DEVICES (INCLUDING E-CIGARETTES)

The Government is now working with local authorities to crack down on novel nicotine delivery devices (including e-cigarettes) that contain toxic levels of chemicals, ensuring that they are labelled and sold appropriately. We would strongly recommend that consumers who are trying to stop smoking use effective evidence-based approaches such as those available via the NHS local Stop Smoking Services, e.g. NRT.

The Government in England is working hard to identify any potential risks to consumers and to put protective mechanisms in place to safeguard their health. Many of the novel nicotine delivery devices (including e-cigarettes) do not contain tobacco and so are outside the scope of the UK Tobacco Products (Manufacture, Presentation and Sale) (Safety) Regulations 2002. DH is working with local authorities to ensure that correct and informative labelling is in place, as is necessary under general product safety laws. Any products that do not have the appropriate safety warnings – such as being marked as ‘highly toxic’ – the application of tactile warnings, child-resistant fastenings and the right packaging should not therefore be on sale in the UK.

88 Hey K and Perera R (2005) ‘Competitions and incentives for smoking cessation.’ Cochrane Database of Systematic Reviews, Issue 2
Priority population groups

ROUTINE AND MANUAL GROUPS

Evidence rating: B

Smokers from routine and manual (R/M) groups make up 44% of the overall smoking population. The latest available data indicates that they account for a similar percentage of NHS Stop Smoking Service clients (when taken as a percentage of the three main socio-economic groups, which is the closest comparison that can be made).\textsuperscript{89} However, the percentage varies considerably between regions and PCTs. PCTs will therefore need to ensure that local promotions target R/M smokers effectively.

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

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

Progress is being made. Smoking rates within the R/M grouping have dropped 3% to 26% (compared with a drop of 1% to 21% in the overall adult population) on the previous year\textsuperscript{90} and DH is on track to achieve the 2010 targets. However, the scale of the challenge for reducing R/M smoking prevalence should not be underestimated.


\textsuperscript{90} Office for National Statistics (2009) Smoking and drinking amongst adults, 2007. ONS
Who are routine and manual smokers?
In 2007, there were an estimated 14.4 million people in R/M groups. Nearly 60% were male, 42% were aged 25–44 (compared with 35% of the general population) and 39% had children aged 0–15 (compared with 31% of the general population). There were approximately 3.8 million R/M smokers. Smoking prevalence was higher among men (28%) than women (24%). There is a significant overlap between the R/M population and the C2D socio-economic grouping.

Table 11: Routine and manual occupations and the gender divide

<table>
<thead>
<tr>
<th>Male R/M occupations</th>
<th>Female R/M occupations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transport and haulage (363,000 HGV drivers)</td>
<td>Sales and retail (884,000)</td>
</tr>
<tr>
<td>Construction (169,000 labourers, 139,000 construction trades)</td>
<td>Carers (581,000)</td>
</tr>
<tr>
<td>Manufacturing (139,000 in metalwork and maintenance)</td>
<td>Cleaners/domestic staff (549,000)</td>
</tr>
<tr>
<td>Sales and retail (233,000)</td>
<td>Educational assistants (295,000)</td>
</tr>
<tr>
<td>Other blue-collar trades (174,000 van drivers, 154,000 carpenters)</td>
<td>Kitchen/catering (288,000 assistants, 113,000 chefs/cooks)</td>
</tr>
<tr>
<td>Security (156,000 security guards)</td>
<td>Receptionists (220,000)</td>
</tr>
<tr>
<td></td>
<td>Hairdressers (109,000)</td>
</tr>
</tbody>
</table>
Approximately 85% of R/M workers are in the C2D segment

Approximately 60% of C2Ds are R/M workers

Research insights into routine and manual smokers

Evidence from recent research provides some insight into smoking and quitting behaviour among R/M groups. Smoking is strongly associated with social disadvantage, and higher levels of prevalence and tobacco addiction are often found in the most disadvantaged areas.91 Disadvantaged smokers, however, are just as likely to want to quit as affluent smokers.92 The lack of a significant decline in prevalence in this group may be partially due to the barriers that affect service use but also relate to issues associated with addiction and wider life circumstances. A number of studies have been undertaken with smokers to identify these types of barriers and explore how they can be overcome. These have been summarised in a recent review for NICE.93

The review highlights a study by Roddy and colleagues,94 who conducted focus groups with 39 socio-economically deprived smokers in Nottingham. These were used to explore how the smokers viewed cessation services and aimed to identify specific barriers and motivations to improve access to cessation services. The study concluded that these smokers displayed a fear of being judged and a fear of failure, and demonstrated a lack of correct knowledge about cessation services and the medication available. It was recommended that services be promoted in a personalised, non-judgemental and flexible manner.

Another study, conducted by Wiltshire and colleagues,95 involved interviews with 100 disadvantaged smokers in Edinburgh to investigate their perceptions of smoking and past experiences of quit attempts. The study found that smokers lack the motivation to access cessation services unless they feel they will not only get help with their nicotine addiction but also with the wider life circumstances, routines and stressors linked to their smoking habits.

93 Bauld L, McNeill A, Hackshaw L and Murray R (2007) The effectiveness of smoking cessation interventions to reduce the rates of premature death in disadvantaged areas through proactive case finding, retention and access to services. NICE. www.nice.org.uk/guidance/index.jsp?action=download&o=37495
More recent work by Kotz and West,96 using data from the Smoking Toolkit Study, shows that smokers in more deprived groups are just as likely as those in higher groups to try to stop and use aids to cessation, but there is a strong gradient across socio-economic groups in success rates. Those in the lowest group are half as likely to succeed compared with the highest. Determining the cause of, and counteracting, this gradient is paramount in reducing health inequalities.

Higher levels of nicotine addiction may be one factor explaining this. Kotz and West’s study confirms previous reports of higher nicotine dependence scores in smokers from more deprived groups, and nicotine dependence can predict failure of attempts to stop smoking. However, other factors have a role to play. Smokers in more deprived groups will have more smokers in their immediate circle of family, co-workers and friends. They may also have higher levels of stress, which can play a role in relapse.97

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

**Working with routine and manual employers**

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

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

**HOSPITALISED AND PRE-OPERATIVE PATIENTS**

*Evidence rating: A*

**Planned admissions**

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

A recent Cochrane review reported that delivering stop smoking services to 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.98

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96 Kotz D and West R (2009) ‘Explaining the social gradient in smoking cessation: it’s not in the trying, but in the succeeding.’ Tobacco Control 18:43–6

97 Ibid

**Recommendations**

- All patients should receive brief intervention advice in advance of any surgical intervention and be referred for more intensive support from their local NHS Stop Smoking Service (see page 36).

- Patients who do not intend to stop smoking prior to surgery should be advised of the hospital’s Smokefree policy. As smokers are likely to experience withdrawal symptoms during a period of enforced abstinence, pharmacotherapy should be offered to assist withdrawal management and provided through primary care.

**Unplanned admissions**

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

**Recommendations**

- If the patient wishes to stop smoking following admission to hospital, they should be given brief intervention advice and referred for intensive support.

- All smokers’ nicotine dependency scores should be assessed following admission and NRT provided as soon as possible.

- Patients should not have to wait for their local NHS Stop Smoking Service (either provided internally or externally) to assess them before receiving NRT.

- NHS Stop Smoking Services should be prepared to support patients who have stopped smoking in hospital once they return to the community. Discharge information from the hospital will need to be communicated to the service via a locally agreed system.

**Stop smoking interventions in secondary care**

The DH Tobacco Policy Team, with the aid of an expert working group, has produced a guide to help NHS Stop Smoking Services develop planned and unplanned stop smoking support across acute settings. The stop smoking interventions in secondary care guidance is based on the premise that planned and unplanned admissions to hospital provide ideal opportunities to support people in stopping smoking. Phase one of this approach was launched in June 2009, although evaluation data will not be available until spring 2010. Phase two was launched in October 2009, making the total number of services implementing the approach an impressive 84.

**Commissioning tool**

In addition, this year NICE published a tool to help NHS Stop Smoking Services demonstrate the financial and clinical impact of pre-operative stop smoking support services in acute settings to both acute and primary care commissioners. To access the tool, see [www.nice.org.uk/usingguidance/commissioningguides/commissioning_tool_log_in.jsp](http://www.nice.org.uk/usingguidance/commissioningguides/commissioning_tool_log_in.jsp).
BLACK AND MINORITY ETHNIC GROUPS

Evidence rating: B

Some black and minority ethnic (BME) communities have high smoking prevalence rates compared with the general population (see Table 12). Rates are highest among Bangladeshi, Irish and Pakistani males.

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

There has been a wide range of innovative work to deliver NHS Stop Smoking Services to BME communities across the country. Specific guidance has been issued by Communities and Local Government to highlight models of good practice and ways of increasing service uptake by smokers from local BME communities.99

A number of areas have been networking with local faith groups and using local multilingual media to promote NHS Stop Smoking Services.

NHS ASIAN TOBACCO HELPLINES

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

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

Table 12: Ethnicity, gender and smoking

Self-reported cigarette smoking by sex and ethnic group (adults aged 16 and over), England, 2004.100

<table>
<thead>
<tr>
<th></th>
<th>General population</th>
<th>Black Caribbean</th>
<th>Indian</th>
<th>Pakistani</th>
<th>Bangladeshi</th>
<th>Chinese</th>
<th>Irish</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Women</td>
<td>24</td>
<td>25</td>
<td>20</td>
<td>29</td>
<td>40</td>
<td>21</td>
<td>30</td>
</tr>
</tbody>
</table>

Source: Health Survey for England 2004: The health of minority ethnic groups

CHILDREN AND YOUNG PEOPLE

**Evidence rating:** I

There is little published evidence of the effects of interventions that focus on cessation activity in adolescence.\(^{101}\) Data from English NHS Stop Smoking Services shows a 63% CO-verified quit rate in the under-18 age group against 67% in all ages.\(^{102}\)

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

**Prevention and tobacco control**

**Evidence rating:** B

The evidence base for preventative strategies aimed at young people is improving. These include ASSIST\(^{103}\) and wider tobacco controls aimed at denormalising smoking. However, these initiatives are driven by wider public health and tobacco control teams, so should not be a major focus of the clinical intervention service.

**Smokefree homes in England**


A recent publication, which examined data from a series of Health Surveys for England from 1996 to 2007,\(^ {104}\) has identified a marked trend towards smokefree homes as well as a decline in cotinine concentrations in children living within smokefree homes.

**School-based interventions**

NICE is due to publish guidance regarding school interventions to prevent the uptake of smoking among children. This is expected in spring 2010.

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SMOKERS WITH MENTAL HEALTH PROBLEMS

Evidence rating: B

On 1 July 2008, it became a legal requirement for all mental health facilities to be smokefree. This presents a particular challenge since smoking prevalence among people with mental health problems is far greater than that in the general population. However, since the majority of those with mental illness are treated in the community by primary care and community mental health services, improved co-ordination with stop smoking services will support smoking cessation in this group.

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

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

Such high levels of smoking increase the amount of smoking-related harm people with mental health disorders suffer. It is responsible for a large proportion of the excess mortality of people with mental health problems. The death rate from respiratory disease among people with schizophrenia, for example, is 10 times higher than the average. It is therefore crucial that people with mental health problems should have appropriate access to stop smoking support and be encouraged to stop.

Smoking cessation and inequality reduction

Since increased levels of smoking are responsible for a large proportion of health inequality in this group, supporting people with mental health problems to stop smoking can have a direct impact on reducing health inequalities. However, health inequality experienced by people with mental illness will widen if investment in smoking cessation services for this group is not greater than for the general population.

Making access to smoking cessation services easier for those with a disability due to severe mental disorder will also comply with the Equality Act 2006.
Positive effects of smoking cessation on mental health

Evidence suggests that there is a link between the amount smoked and the number of depressive and anxiety symptoms. On stopping, these symptoms are seen to reduce and can be accompanied by a sense of achievement. However, a minority of people with depression who stop smoking experience an increase in depressive symptoms.

Smoking cessation and depression

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

Smoking cessation and schizophrenia

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

Stopping smoking and medication

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

Medications affected in this way include, among many others:

- benzodiazepines: diazepam, zotepine
- antipsychotic medication: clozapine, fluphenazine, perphenazine, haloperidol (partly), olanzapine (partly)
- antidepressants: tricyclics – tertiary (e.g. amitriptyline, clomipramine, desipramine, imipramine), fluvoxamine (partly), mirtazapine (partly).

Client medical history and current medication should always be asked and recorded during the first stop smoking appointment. The GP and 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. Quit status should be regularly reassessed and, if the client relapses, the GP and key mental health worker should again be made aware to ensure appropriate readjustment of medication.

Stop smoking medication and mental health

**NRT** (see page 56) has no specific contraindications or cautions relating to mental health disorders.

**Bupropion** (see page 58) has been shown to be effective for people with depression and schizophrenia, although it has been associated with increased anxiety and depression. It is contraindicated in bipolar disorder and should not be prescribed with drugs that increase the risk of seizures, such as tricyclic antidepressants and some antipsychotic medication. Bupropion can also increase blood levels of citalopram, which should be avoided for two weeks after stopping. It is also contraindicated with monoamine oxidase inhibitors (MAOIs).

**Varenicline** (see page 58) is not contraindicated for use in mental health, although the SPC advises particular care in patients with a previous history of psychiatric illness, and states that patients, family members and caregivers should be advised accordingly.

Patients should be advised to stop taking varenicline (or bupropion) and contact a healthcare provider immediately if they experience agitation, depressed mood, or suicidal thoughts or behaviour. Close regular monitoring by health professionals, including stop smoking advisers, 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. If varenicline (or bupropion) is stopped due to neuropsychiatric symptoms, patients should be monitored until the symptoms resolve and this should be reported using the Yellow Card Scheme (see www.yellowcard.mhra.gov.uk/).

For a complete list of all contraindications and cautions, refer to the SPC for each product. These are available at www.emc.medicines.org.uk.

Stop smoking interventions in mental health

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

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

☐ Offer a menu of evidence-based support options.
☐ Ensure that the intervention is delivered by a trained stop smoking adviser.
☐ Allow access to approved pharmacotherapy.
☐ Use CO verification in at least 85% of cases (see page 44).
☐ Provide support for the duration of the treatment episode.

An example care pathway, including these principles, can be found at Annex F.

**Recommendations**

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

**Community settings**

☐ Ensure that the local mental health trust is aware of the local NHS Stop Smoking Service.
☐ Train all mental health colleagues (including local community mental health teams and voluntary sector helpers) and ensure that there is a referral pathway into the local NHS Stop Smoking Service.
☐ Ensure that stop smoking advisers understand the potential interactions between smoking and psychiatric medications and the need to communicate with relevant prescribers (in primary and secondary care) about stop smoking attempts so that appropriate changes in medication doses can be made.
☐ Co-ordinate basic training for stop smoking advisers with the local mental health trust to increase their confidence in dealing with clients with a history of mental health problems.
☐ Offer training for people working in primary care to help them understand the issues people with mental health problems face when they try to stop smoking.
☐ Maintain links with local mental health services and seek guidance when specific issues arise.
Acute settings

- Seek out top-level approval and support.
- Provide brief or intermediate training for staff and ensure that this is part of regular training. A champion who can offer ongoing support for practical issues arising on the ward can support such training.
- Ensure that stop smoking medicines are available for patients who wish to stop smoking and those who require withdrawal management (i.e. those who do not wish to stop smoking but have limited access to outdoor space and opportunities to smoke and therefore experience nicotine withdrawal symptoms).
- Ensure that stop smoking medicines are available for staff.
- Create a clear pathway to maintain support once the patient has been discharged into the community.

PREGNANCY

Evidence rating: B

Smoking is the single most modifiable risk factor for adverse outcomes in pregnancy. It is estimated to contribute to 40% of all infant deaths, 12.5% increased risk of a premature birth and 26.3% increased risk of intra-uterine growth restriction.¹²¹ This therefore remains a key public health concern, particularly since early intervention (i.e. stopping smoking at three months gestation) significantly improves outcomes.¹²²

The Healthy Child Programme


Pregnant smokers should be offered a full range of services and there should be a robust care pathway that allows women to be tracked through their quit attempts. This should include biochemical verification (see Biochemical markers on page 44).

Between April 2008 and March 2009, 18,928 pregnant women set a quit date, with a success rate of 46% (8,639) and a total of 53% CO validated.¹²³

Nicotine replacement therapy in pregnancy

**Evidence rating:** C

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

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

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

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

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

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

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

**Demographic variations**

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

Mothers in R/M occupations are more than four times as likely to have smoked throughout pregnancy as those in managerial and professional occupations. NHS Stop Smoking Services should therefore find ways of targeting or continuing to target this group of women, using, for example, referral pathways and outreach with community health professionals as well as partnerships with organisations such as Children’s Centres. Services should also refer to the section on R/M smokers (see page 63) for guidance on this particular sector of the population.

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125 See [www.biomedcentral.com/1472-6963/7/2](http://www.biomedcentral.com/1472-6963/7/2)
Improving data quality
The quality of data on the smoking status of women during pregnancy and at delivery is poor in some areas. Efforts should be made to improve both the frequency of data recording and the quality of the data collected.

SMOKING CESSATION IN PREGNANCY: NICE GUIDANCE RECOMMENDATION 8\textsuperscript{129}

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

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

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

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

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

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

Forthcoming guidance
NICE guidance on quitting smoking in pregnancy and childbirth is due to be published in 2010. DH will be publishing stop smoking in pregnancy interim guidance; this has been developed in response to an urgent expressed need by commissioners for practical guidance in this area. This interim document is not intended to pre-empt the NICE guidance and will be reviewed once this has been published.

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

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

TEENAGE PREGNANCY

Evidence rating: 
Teenage mothers are more likely than older mothers to have been smoking before they become pregnant. They are also less likely to stop smoking during their pregnancy (see Table 13). This group is therefore a priority for stop smoking support.

Table 13: Smoking during pregnancy in England by mother’s age, 2005

<table>
<thead>
<tr>
<th>Mother's age</th>
<th>% who smoked before or during pregnancy</th>
<th>% who smoked throughout pregnancy</th>
<th>% who gave up before or during pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 or under</td>
<td>68</td>
<td>45</td>
<td>34</td>
</tr>
<tr>
<td>All ages</td>
<td>32</td>
<td>17</td>
<td>49</td>
</tr>
</tbody>
</table>


The Family Nurse Partnership programme
The Family Nurse Partnership programme is an intensive preventative programme for first-time teenage mothers that begins in early pregnancy and continues until the child is two years old. Three large-scale research trials in the US have shown significant and consistent benefits to children and their mothers, including a reduction in smoking in pregnancy. The programme is being tested in 50 sites across England and early impacts look promising. Smoking in pregnancy decreased from 40% to 32% (a 20% relative reduction) in the first cohort of clients. The research trial in England has smoking in pregnancy as a primary outcome measure.

Recommendations for both NHS Stop Smoking Services and midwifery services on helping teenage smokers to quit can be found in the Department for Children, Schools and Families’ 2007 report Teenage Parents Next Steps: Guidance for Local Authorities and Primary Care Trusts.130

PRISONERS

Evidence rating: C

It has been estimated that around 80% of the prison population smokes.131 Data for 2008/09 from the English NHS Stop Smoking Services shows that 9,907 quit dates were set in a prison setting with a self-reported success rate of 61% (5,996).132

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

- Offer a menu of evidence-based support options.
- Ensure that the intervention is delivered by a trained stop smoking adviser.
- Allow access to approved pharmacotherapy.
- Use CO validation in at least 85% of cases (see the CO section on page 44).
- Provide support for the duration of the treatment episode.

Department of Health best practice checklist

Between April 2004 and March 2005, DH funded a study of smoking in prisons across the North West region.133 The aims of the study were to:

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

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

- **Effective partnership should be developed between the PCT and the prison**: this is essential for any intervention and means building relationships throughout the healthcare and wider prison system through continuous planning and feedback mechanisms for cessation and wider tobacco control issues.

- **A range of cessation delivery models should be available**, including both group and one-to-one support. These should offer flexible support that meets individual needs. Services can be offered through a range of prison staff, not just healthcare staff but others such as physical education instructors or prison officers. External stop smoking specialists may run support sessions but it is vital that internal prison staff remain involved.

- **Protected staff time and role development for those delivering the service need to be secured**: this means not just time for core interactions with quitters, but for administration and record-keeping activities that may be more demanding in prisons than in community settings. If dedicated time is set aside, then prison staff and stop smoking advisers will be able to plan programme sessions in advance. There should be enough staff to provide a substantial service, led by an enthusiastic ‘champion’ who promotes the service, co-ordinates activities and liaises across organisations. Cessation can therefore form part of their core work.

- **Clear record keeping will make it easier to promote the service**: telling people what is happening and ‘selling’ the successes of the service are important ways of providing rewarding feedback to those delivering the service and making a case for future developments.

- **Assessing and exploiting the expressed desire to quit among prisoners**, as well as interest from staff, will contribute to building the service. Conducting needs assessments and keeping track of waiting lists will help.

- **Ring-fenced NRT budgets for prisoners** and a long-term funding commitment are recommended. Efficient and economical ordering procedures and effective supply mechanisms should be developed across areas, in conjunction with prison pharmacies and pharmaceutical companies.

- **Straightforward NRT prescribing and dispensing** should be developed within the context of safety issues. Experience shows that dispensing NRT on a weekly basis, with used patches being returned, achieves a better balance between empowering prisoners and minimising the misuse of NRT as currency. Consistent guidance is needed, for example in the use of alternative NRT oral/non-gum products.

- **Staff training and ongoing support** by stop smoking specialist services will contribute to high standards and will increase confidence among those delivering the service. Network meetings are valuable.

- **Care pathways** should be developed with mechanisms to cope with prisoners being transferred from one prison to another or released during a course of treatment (Prison Service Order 3050).
Staff cessation support should be considered, within the prison or through links to community settings.

Being aware of relevant legislation and anticipating guidance on prisoner health and workplace issues will help planning and preparation and so increase the effectiveness of your interventions.

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

Interventions for substance misuse

Evidence rating: C

SMOKING AND ALCOHOL

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

SMOKING AND ILLICIT DRUGS

More than two-thirds of drug misusers are regular tobacco smokers – double the rate in the general population. A cross-sectional survey of outpatients enrolled in four urban methadone maintenance clinics found a tobacco prevalence of 83%, although there was a high level of readiness to quit and interest in smoking cessation. Smoking status has also been found to be predictive of illicit substance use in methadone maintenance programmes, although there is a significant relationship between rates of change in heroin use and rates of change in tobacco use.

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

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

- **develop links with alcohol and drug services** within their area to create referral pathways from the drug or alcohol services into the NHS Stop Smoking Services and vice versa

- **train colleagues in local drug and alcohol services, as appropriate**, in brief interventions (see page 36) to facilitate referrals into NHS Stop Smoking Services

- **train stop smoking advisers, as appropriate for the needs of the population attending the service**, to deliver suitable information and advice on cannabis smoking and brief interventions concerning excessive alcohol use.
Relapse prevention

Evidence rating: 1

There is currently little evidence suggesting which interventions are most likely to prevent people partially or totally resuming smoking, \(^{142}\) although research in this area is ongoing. As yet, we are not aware of any published data on relapse rates by time among treated smokers. Survival rates among the general untreated population, however, are shown in the figure below.

Figure 4: Relapse curve

![Figure 4: Relapse curve](image)

True survival curves (solid lines) and line-graph relapse curves (dotted lines) in self-quitters (open circles and triangles) and those in control groups (solid circles and triangles) taken from Hughes et al.\(^{143}\)

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Repeat service users

Evidence rating: ✅

Smokers often need several attempts before stopping successfully. Anyone who has made a previous, unsuccessful, quit attempt, should therefore be offered brief advice on how to stop smoking (see page 36). As the majority of successful quit attempts are unplanned or spontaneous, smokers should also be enabled to stop whenever they want to (see Time between treatment episodes on page 97).\textsuperscript{144}

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

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

Formal data is collected through more detailed, quarterly data collections (ROCR/OR/0028/009). Since the beginning of 2008/09, primary care trusts (PCTs) have submitted returns electronically directly to the NHS Information Centre (IC), whereas previously this happened through strategic health authorities (SHAs).

In response to the concerns of the Care Quality Commission (CQC) (formerly known as the Healthcare Commissions) about data quality, changes to the system were also introduced in 2008/09. These included the exception reporting system, a new data verification and checking process that is now used by PCT smoking and clinical governance leads to ensure that the right definitions have been used and that results that fall outside an expected success rate range (derived from smoking cessation literature) are investigated (see below).

At the end of the monitoring period (a quarter plus six weeks), PCTs have a further four weeks to submit data to the IC in the case of Quarters 1 to 3 and five weeks in the case of Quarter 4 data. This means that, at the end of the quarter, SHAs have a total of 10 weeks to submit returns 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 (due to the deadline for the CQC’s Annual Health Check). Under this system, however, more time is available for submission of Quarter 4 data than for any other quarter. Late data from Quarter 4 may not be carried into Quarter 1 of the next reporting year.

For the first three quarters of the year, the IC produces three sets of tables at national, SHA and PCT levels accompanied by a summary describing key results. Within the Quarter 4 annual report all provisional figures from previous quarters are confirmed and figures are deemed final. Extensive analysis is conducted at this point and a much more comprehensive report is produced. All published reports can be found on the NHS Information Centre website, www.ic.nhs.uk.

### Table 14: 2009/10 returns timetable

<table>
<thead>
<tr>
<th>Quarter</th>
<th>End of six-week follow-up period</th>
<th>PCT deadline to submit data to IC and elapsed weeks</th>
<th>Date for publication by IC website</th>
</tr>
</thead>
<tbody>
<tr>
<td>April to June</td>
<td>12/08/2009</td>
<td>09/09/2009 (4wks)</td>
<td>Published on 08/10/09</td>
</tr>
<tr>
<td>July to September</td>
<td>12/11/2009</td>
<td>10/12/2009 (4wks)</td>
<td>W/C 18/01/10 (provisional)</td>
</tr>
<tr>
<td>October to December</td>
<td>12/02/2010</td>
<td>12/03/2010 (4wks)</td>
<td>W/C 12/04/10 (provisional)</td>
</tr>
<tr>
<td>January to March</td>
<td>13/05/2010</td>
<td>17/06/2010 (5wks)</td>
<td>W/C 16/08/10 (provisional)</td>
</tr>
</tbody>
</table>

Work is underway to develop a receipt mechanism to acknowledge submission and validation of quarterly returns. This is expected to be active early in 2010.

**The monitoring and reporting process for 2010/11**

There are no substantive changes to the quarterly monitoring and reporting process for 2010/11, although those changes introduced in 2009/10 will be carried forward. This includes there no longer being a requirement to collect data relating to carbon monoxide (CO) validation attempts. As a result, this information no longer needs to be entered on the quarterly monitoring form which is submitted to the IC. The requirement to submit monthly data on the number of four-week quitters through the UNIFY system ceased in November 2008.

SHAs are welcome to carry on submitting monthly statistics in this way if they find it beneficial, but we know that some SHAs have chosen to opt out. Any data submitted on a monthly basis through UNIFY is therefore only relevant to individual SHAs. No monthly national picture of NHS Stop Smoking Services is available.
'GOLD STANDARD’ MONITORING
To encourage greater consistency in the data collected from the stop smoking service network we have devised a ‘gold standard’ monitoring form (see Annex H). This has recently been amended for the purposes of clarification. To improve consistency, we would urge services to use this form or adapt existing forms to include the same content; for example, when services are ready to reprint stocks of this form, they should use the new double-sided version. An electronic version of the form can be downloaded at www.smokefree.nhs.uk/resources.

RECORDING THE OCCUPATION OF PRISONERS – KEY POINT TO NOTE
The ‘prisoner’ occupation category has been added to the quarterly monitoring form submitted to the IC for 2009/10 onwards in an effort to reduce the number of clients recorded as ‘unable to code’. This change is reflected in the 2010/11 Gold Standard Monitoring form, having been introduced too late for the 2009/10 form. With the exception of prison staff, clients treated in prison should all be recorded as prisoners.

Services will already have more detailed client record forms that provide information about each stage of treatment as well as client motivation and quit history. Some PCTs have also invested in web-based information systems to help streamline their data collection processes and analyse service performance. Such systems can be of great benefit to commissioners and have proved a highly worthwhile investment in a number of areas.

POTENTIAL ADDITIONAL INFORMATION TO ENHANCE LOCAL PLANNING AND ASSESSMENT
The following points of additional information may be useful for commissioners and providers of services but are not required in the quarterly returns.

- GP name and address
- Referral source
- Intervention provider
- Combination nicotine replacement therapy (NRT) use.

DEFINITIONS AND DATA QUALITY
It is important that we respond to the concerns of the CQC. It is therefore essential that all NHS Stop Smoking Services adopt strict criteria when deciding who to include in their monitoring return, and the four-week quit status of a client. These criteria also need to be applied consistently. When recording the numbers of smokers entering treatment and the numbers successfully quit at four weeks, it is essential that all services adhere to the definitions given in Annex D (see page 94).
The purpose of the data monitoring system is to monitor and evaluate the effectiveness and reach of NHS Stop Smoking Services. It is designed to provide consistent information on people who have sought and received quitting help from an evidence-based NHS Stop Smoking Service. **It is not a mechanism for counting all people who have stopped smoking in a locality, nor is it a prevalence measure.** For this reason it should not include quits that have not resulted from structured stop smoking interventions delivered by stop smoking advisers.

**COST PER QUITTER**

Work is underway to develop clear guidance regarding cost per quitter submissions; however, in the interim, it should be noted that only monies spent on smoking cessation activity, not wider tobacco control measures, should be included in these calculations.

**ENCOURAGING HONEST SELF-REPORTS**

When carrying out four-week quit status checks, it is vital that staff phrase their questions in a way that encourages honest answers. For example: ‘Are you sure that you haven’t smoked at all in the past 2 weeks? Not even a puff?’ 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?

- 🟠 I haven’t smoked at all since my quit date, not even a puff
- 🟠 I did have the odd puff/cigarette early on in my quit attempt but haven’t smoked at all in the last 2 weeks, not even a puff
- 🟠 I have had the odd cigarette/puff in the last 2 weeks
- 🟠 I am still smoking but have cut down

**DISABILITY DISCRIMINATION ACT**

Amendments to the Disability Discrimination Act 1995, which came into force in December 2006, require all NHS Authorities to actively promote disability equality and monitor their compliance with it. To ensure compliance with this legal requirement, DH also published a practical guide to help NHS organisations develop disability equality schemes.145

Exception reporting system

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

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

☐ The service provider or adviser should be contacted and asked to confirm that all definitions contained within the guidance have been followed. If this is not the case, then the total number of successful four-week quits should be recalculated using the approved definitions and the data re-entered onto the service database.

☐ If the service provider or adviser asserts that the approved definitions have been used, a minimum of three random checks of smokers treated by the service provider concerned should be carried out by telephone (or face to face if possible). This should establish whether they meet the criteria for self-reported or CO verified four-week quits at the four-week follow-up point and whether they have received an approved intervention of the required content and duration. A minimum of three successful random calls to clients must be made, so if attempts to contact one client fail, another client should be selected. If the random checks indicate that recorded quits are unreliable, all cases received from this provider should be checked using the approved definitions and the total number of four-week quits should be re-entered onto the service database. If, after the required checks have been carried out, the results are still outside the expected range, an assessment should be made of the most likely causes.

☐ To facilitate service audits and comply with clinical governance, all service providers should maintain adequate client records (to include all client contacts, medications used and smoking status). Service providers should return data on all clients treated (not just on successful outcomes) so that success rates may be accurately calculated. These requirements should be specified in service level agreements.

☐ Service providers or advisers who repeatedly submit incorrect or incomplete data should receive refresher training in the approved definitions and procedures. Any data they submit should be subject to regular spot checks until the service lead is satisfied that the correct procedures and definitions are being used. It is especially important to monitor the data supplied by providers who are paid for their work or for successful four-week quit data under a Service Level Agreement (SLA). This will ensure that quitters are receiving the appropriate treatment and that the service is getting value for money.

☐ Extenuating circumstances that may clarify otherwise unexplained outlying data should be recorded in the comments box in the exception reporting section of the quarterly return. If the extenuating circumstances in a given case are not contained within the drop-down menu, the service lead should select ‘other’ and explain the circumstances using free text.
Figure 5: The exception reporting procedure

1. Service lead checks success rates of all intervention types and settings.
2. Service lead and PCT lead carry out checks with service providers regarding any outlying data.
3. Service lead recalculates quit totals and completes extenuating circumstances section of return if data still outlying.
4. PCT lead notifies SHA of results of exception reporting procedure.
5. Service lead submits data to IC.
ANNEX A: THE SMOKEFREE RESOURCE CENTRE

The Smokefree Resource Centre (www.smokefree.nhs.uk/resources) is an online resource to support those passionate about reducing the prevalence of smoking in England. It contains comprehensive links to a wide range of policy, guidance, latest campaign information, marketing templates and free resources relevant to this area.

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

The site will be reviewed regularly and new resources and functionality will be added on an ongoing basis. If you have any comments on the site please contact smokingorders@coi.gsi.gov.uk.
ANNEX B: USEFUL CONTACTS

Your first point of contact should be either your regional tobacco policy manager (RTPM) or, if there is one, the regional development manager (RDM). Communications-related matters should be addressed to the regional communications manager (RCM), where in post.

**North East**
Ailsa Rutter (RTPM) Ailsa.Rutter@freshne.com
Martyn Willmore (RDM) Martyn.Willmore@freshne.com
Andy Lloyd (RCM) Andy.Lloyd@freshne.com

**North West**
Andrea Crossfield (RTPM) andrea.crossfield@smokefreenorthwest.org.uk
Hadas Altwarg (RCM) hadas.altwarg@smokefreenorthwest.org.uk

**Yorkshire & Humber**
Patricia Hodgson (RTPM) patricia.hodgson@dh.gsi.gov.uk
Madge Boyle (RDM) madge.boyle@dh.gsi.gov.uk
Scott Crosby (RCM) scott.crosby@dh.gsi.gov.uk

**West Midlands**
Paul Hooper (RTPM) ph7@blueyonder.co.uk
Aaron Bohannon (RDM) aaron.bohannon@gmail.com
Alex Johnson (RCM) alexjohnsonmail@googlemail.com

**East Midlands**
Andrew Head (RTPM) andrew.head@dh.gsi.gov.uk
Helen Shields (RDM) helen.shields@dh.gsi.gov.uk
Amandeep Kaur (RCM) amandeep.kaur@dh.gsi.gov.uk

**East of England**
(RTPM) TBC
Hilary Andrews (RDM) hilary.andrews@eoe.nhs.uk

**London**
Andrew Hayes (RTPM) andrew.hayes@dh.gsi.gov.uk
Ghazaleh Pashmi (Assistant RTPM) ghazaleh.pashmi@dh.gsi.gov.uk
Dominick Nguyen (RCM) dominick.nguyen@dh.gsi.gov.uk
South East
Joanne Locker (RTPM) joanne.locker@dh.gsi.gov.uk
Ruth Finlay (RDM) ruth.finlay@dh.gsi.gov.uk
Katy Taylor (RCM) katy.taylor@coi.gsi.gov.uk

South West
Fiona Andrews (RTPM) fiona.andrews@smokefreesouthwest.org.uk
Juniper Connal (RDM Southern) juniper.connal@smokefreesouthwest.org.uk
Andrea Dickens (RDM Northern) andrea.dickens@smokefreesouthwest.org.uk
Melissa Cullum (RCM Southern) melissa.cullum@smokefreesouthwest.org.uk
Kate Barrett (RCM Northern) kate.barrett@smokefreesouthwest.org.uk

National Support Team (NST) for Tobacco Control
Tel: 0207 972 3014
Sarah Wyatt, NST Head of Tobacco Control
Gail Addison, Associate Delivery Manager
Clair Harris, Associate Delivery Manager
Lynne Kilner, Associate Delivery Manager
Dale Ricketts, Associate Delivery Manager

NHS Centre for Smoking Cessation and Training (NCSCT)
Lisa Cheung – NCSCT Centre Manager lisa.cheung@ncsct.co.uk

DH Tobacco Policy Team
Emma Croghan – Team Leader – Supporting Local Tobacco Control
Melanie Chambers – Delivery Manager for Smoking Cessation
Sarah Edwards – Delivery Manager for Smoking Cessation

OTHER USEFUL CONTACTS
NHS Stop Smoking Helplines 0800 169 0 169
NHS Pregnancy Smoking Helpline 0800 169 9 169
NHS Asian Tobacco Helpline
- Urdu 0800 169 0 881
- Punjabi 0800 169 0 882
- Hindi 0800 169 0 883
- Gujarati 0800 169 0 884
- Bengali 0800 169 0 885
The Health and Safety Executive 0800 300 363
ANNEX C: USEFUL RESOURCES

The Smokefree Resource Centre www.smokefree.nhs.uk/resources
Smokefree campaign website www.nhs.uk/smokefree with information, tools and video content for smokers who want to go smokefree. Smokers can also look up their local NHS Stop Smoking Service.
NHS Centre for Smoking Cessation and Training www.ncsct.co.uk – keep up to date with latest developments from the centre.
Cochrane reviews www.cochrane.org/reviews/
National Institute of Health and Clinical Excellence (NICE) www.nice.org.uk/
Medicines and Healthcare products Regulatory Agency (MHRA) www.mhra.gov.uk/index.htm
Electronic Medicines Compendium http://emc.medicines.org.uk/
Smoking Cessation Service Research Network (SCSRN) www.scsrn.org/
GLOBALink www.globalink.org/
Action on Smoking and Health www.ash.org.uk/
ANNEX D: DEFINITIONS

Bank staff
Indicates staff involved in the delivery of NHS stop smoking interventions who have been trained to HDA standards (until 1 April 2010, when these will be superseded by the NCSCT standards www.ncsct.co.uk) and who are paid to provide these services outside their normal working hours.

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

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

The percentage of self-reported four-week quitters who have been CO verified should be calculated as shown below:

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

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

Lost to follow-up (LTFU)
A treated smoker who cannot be contacted either face to face or via telephone, email, letter or text following three attempts to contact 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.

Monthly monitoring
Voluntary monthly collection and reporting system for which local stop smoking services collect and report data on the numbers of smokers entering treatment and setting a quit date and the numbers recorded as quit. This return is now optional (as of November 2008).
NHS Stop Smoking Service
An NHS Stop Smoking Service is defined as a locally managed, co-ordinated and provided service, funded by DH nationally, to provide accessible, evidence-based, cost-effective clinical services to support smokers who want to stop. Service delivery should be in accordance with the quality principles for clinical and financial management contained within this guidance.

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

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

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

Renewed quit 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 as a routine and manual (R/M) worker, as defined by the National Statistics Socio-Economic Classification. Smoking prevalence among the R/M socio-economic grouping is significantly higher than among other groupings. This has a major impact on the health and life expectancy of this grouping.

Self-reported four-week quitter
A treated smoker whose quit status at four weeks from their quit date (or within 25 to 42 days of the quit date) has been assessed (either face to face or by telephone, text, email or postal questionnaire). The percentage of self-reported four-week quitters should be calculated as shown below:

\[
\text{Number of treated smokers who self-report continuous abstinence from smoking from day 14 post-quit date to the 4-week follow-up point} \div \text{All treated smokers}
\]
**Smoked product**
Any product that contains tobacco and produces smoke is a smoked product, including cigarettes (hand-rolled or tailor-made), cigars and pipes. Pipes include shisa, hookah, narghile and hubble-bubble pipes.

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

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

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

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

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

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

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

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

**Stop smoking adviser**
An individual who has received stop smoking service training that meets the published HDA standards\(^{147}\) (until 1 April 2010 when these will be superseded by NCSCT standards [www.ncsct.co.uk](http://www.ncsct.co.uk)) for one-to-one and/or group support and is either an NHS Stop Smoking Service core team member or a trained associate of an NHS Stop Smoking Service.

**Time between treatment episodes**
(see Treatment episode)
When a client has not managed to stop smoking there is no definitive period of time required between the end of a treatment episode and the start of another. The stop smoking adviser should use discretion 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 adviser 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 adviser) on or prior to the quit date, who consents to treatment and sets a quit date with a stop smoking adviser. Smokers who attend a first session but do not consent to treatment or set a quit date should not be counted.

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

---

Figure 6: Treatment episode flow chart

- Lead contacted to offer service by trained stop smoking adviser offering structured multi-session interventions
- Client participates in first session of a structured multi-session intervention, consents to treatment and sets a quit date
- Client participates in weekly sessions of structured multi-session interventions, and receives behavioural support and offer of pharmacotherapy
- EITHER client stops participating and is lost to follow-up (LTFU) OR client relapses after day 14 post-quit date

End of treatment episode

- 4 weeks post-quit date (day 25–42) assessment: face to face if possible, CO recorded where possible (85% of cases minimum)
- Treatment by structured multi-session intervention of behavioural support +/- pharmacotherapy complete as per local protocol (minimum 6 weeks)

- New treatment episode may begin as required at any time following end of previous treatment episode

- The intervention type chosen at this point is the intervention type to be cited in data monitoring

- Lead generated and contacted

- Treatment episode begins – this client is now a treated smoker and should be included in the quarterly data monitoring

- End of treatment episode

- If client has already stopped smoking by this point, they are a spontaneous quitter and should not be counted

- 4-week quit status defined. CO validated quit, Self-reported quit, Not quit/LTFU
Dear Sir/Madam

I realise that you are probably very busy but I am writing to ask whether you could spare just a few minutes to complete a brief survey about your views on the NHS Stop Smoking Service that you recently attended.

I would be very grateful if you could complete the enclosed brief questionnaire and then just post it back to me in the FREEPOST envelope provided within xx days. The information you provide is anonymous and cannot be traced back to you.

We need to get as many people’s responses as possible and so I would be extremely grateful if you could send back the completed questionnaire whatever your views on the stop smoking service.

Thank you for your time.

Yours sincerely

[Insert Service Lead’s name here]
**NHS STOP SMOKING SERVICE CLIENT SATISFACTION SURVEY**

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

Please circle the appropriate number for each question:

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Overall, how satisfied are you with the support you have received to stop smoking?</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2. Would you recommend this service to other smokers who want to stop smoking?</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. In the event that you started smoking again, would you go back to the service for help with stopping smoking?</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. If you returned to the service for help with stopping smoking in the future, do you think that you would be welcomed back?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Have you smoked since your last appointment with the service?</td>
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<td></td>
</tr>
<tr>
<td>6. Was it easy to contact the stop smoking service when you had decided that you wanted to stop smoking?</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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</tr>
</tbody>
</table>
7. When you contacted the stop smoking service, were you given an appointment date or told how long you would have to wait to see someone?  
- No  
- Unsure  
- Yes  

8. How long did you have to wait before your first appointment/group (please enter number of days in box)?  

9. Was the length of time you had to wait for your first appointment acceptable to you?  
- No  
- Unsure  
- Yes  

10. Was there contact from the stop smoking service before your appointment to encourage and motivate you to attend treatment?  
- No  
- Unsure  
- Yes  

11. Are the appointment times you were given convenient for you?  
- No  
- Unsure  
- Yes  

12. Is the place where you go for your appointments convenient for you to get to?  
- No  
- Unsure  
- Yes  

13. Have you been offered support with childcare costs?  
- Not applicable  
- No  
- Unsure  
- Yes  

14. Were you given a choice of an individual appointment or a group?  
- No  
- Unsure  
- Yes  

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

<table>
<thead>
<tr>
<th>Very unsatisfied</th>
<th>Unsatisfied</th>
<th>Unsure</th>
<th>Satisfied</th>
<th>Very satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Very unhelpful</th>
<th>Unhelpful</th>
<th>Unsure</th>
<th>Helpful</th>
<th>Very helpful</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
17. How helpful has the written information that staff have given to you been?

<table>
<thead>
<tr>
<th>None given</th>
<th>Very unhelpful</th>
<th>Unhelpful</th>
<th>Unsure</th>
<th>Helpful</th>
<th>Very helpful</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>CO not taken every visit</th>
<th>Very unhelpful</th>
<th>Unhelpful</th>
<th>Unsure</th>
<th>Helpful</th>
<th>Very helpful</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Unsure</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

20. How did you get your medication?

<table>
<thead>
<tr>
<th></th>
<th>GP prescription</th>
<th>Chemist (bought myself)</th>
<th>Chemist (with a voucher)</th>
<th>Chemist (with service letter or prescription)</th>
<th>The stop smoking service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Unsure</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

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

Now please place the questionnaire in the envelope provided and return it to your stop smoking adviser. Thank you.
ANNEX F: EXAMPLE CARE PATHWAY – MENTAL HEALTH

(adapted from HDA guidance, 2004)148

ANNEX G: EXAMPLE CARE PATHWAY – PRISONS

All existing smokers

- Routine brief advice to stop smoking and referral to local NHS Stop Smoking Service

Specialist advice

Do not want to quit

- Consider pharmacotherapy for withdrawal management while detained

- Regularly review decision not to quit

Want to quit

- Want to quit
  - Provide intensive behavioural support and pharmacotherapy

  Regular monitoring of quit attempt

  Released/transferred
  - Notify local NHS Stop Smoking Service and GP and make follow-up arrangements for provision of ongoing behavioural support and/or pharmacotherapy

  Client relapses
# ANNEX H: GOLD STANDARD MONITORING FORM

**(INSERT SERVICE NAME & ADDRESS) STOP SMOKING SERVICE**

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

## DETAILS:

<table>
<thead>
<tr>
<th>Department/Ward</th>
<th>Location/setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Venue</td>
</tr>
<tr>
<td>Contact tel. no.</td>
<td>Adviser code/ref</td>
</tr>
</tbody>
</table>

## CLIENT DETAILS:

<table>
<thead>
<tr>
<th>Surname</th>
<th>First name</th>
<th>Mr/Mrs/Ms/other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postcode</td>
<td>NHS ID no.</td>
<td></td>
</tr>
<tr>
<td>Daytime tel. no.</td>
<td>Mobile no.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Alternative contact number (friend/relative)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of birth</th>
<th>Age (in years)</th>
<th>Gender</th>
<th>Exempt from prescription charge</th>
<th>Pregnant</th>
<th>Breastfeeding</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Y / N</td>
<td>Y / N</td>
<td>Y / N</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Occupation code</th>
<th>Full-time student</th>
<th>Never worked/long-term unemployed</th>
<th>Home carer</th>
<th>Sick/disabled and unable to work</th>
<th>Managerial/professional</th>
<th>Retired</th>
<th>Intermediate</th>
<th>Routine manual</th>
<th>Prisoner</th>
<th>Unable to code</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

### ETHNIC GROUP (please tick relevant group)

- a) White British
- b) Mixed
- c) Asian or Asian British Indian Pakistani Bangladeshi Other Asian background
- d) Black or Black British Caribbean
- e) Other ethnic groups Chinese
- f) Other (not stated)
- Other Black background

### HOW CLINT HEARD ABOUT THE SERVICE (please tick relevant box)

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

<table>
<thead>
<tr>
<th>Agreed quit date</th>
<th>Date of last tobacco use</th>
<th>Date of 4-week follow-up</th>
</tr>
</thead>
<tbody>
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</table>

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

- Closed group
- Telephone support
- Other (please specify)

- Open (rolling) group
- Couple/family

- One-to-one support
- Drop-in clinic

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

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

### TREATMENT OUTCOME

<table>
<thead>
<tr>
<th>Not quit</th>
<th>Lost to follow-up</th>
<th>Quit self-reported</th>
<th>Quit CO verified</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Adviser signature</th>
<th>Client signature (indicating consent to treatment and follow-up and pass on of outcome data to GP)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.

![Flowchart](chart.png)