2004 Update

Smoking Cessation Guidelines for Scotland

Health Scotland and ASH Scotland

Smoking Cessation Guidelines for Scotland: 2004 Update

A report prepared for Health Scotland (formerly Health Education Board for Scotland and Public Health Institute of Scotland) and ASH Scotland by Robert West, University College, London; Ann McNeill, University College London; Martin Raw, Guy's, King's and St Thomas' School of Medicine, London.

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Professional endorsements

At the time of going to press the following organisations have endorsed the updated guidelines: British Lung Foundation, Cancer Research UK, Chest Heart and Stroke Scotland, McMillan Cancer Relief Scotland, National Asthma Campaign Scotland, Royal College of Nursing Scotland, Royal College of Physicians Edinburgh, The Roy Castle Lung Cancer Foundation.

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Statement of competing interests

Robert West has undertaken research and consultancy for, and received travel funds and hospitality from, manufacturers of smoking cessation medications.

Ann McNeill has received two honoraria, travel funds and hospitality from manufacturers of smoking cessation medications.

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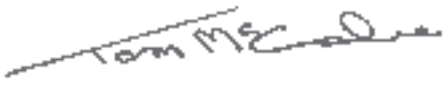
Foreword

Smoking is the biggest single cause of preventable chronic illness, disability and premature death in Scotland. It kills between one half and two thirds of long-term smokers and about 13,000 smokers die each year in Scotland. Many smokers are aware of the health risks and most want to quit, but around 30% of adults continue to smoke because of their addiction to nicotine. In Scotland's most deprived communities smoking rates are even higher at twice the national average.

Since the publication of the Government's White Paper, *Smoking Kills* in December 1998, an infrastructure of specialist smoking cessation services has been developed in every NHS Board in Scotland, and additional funding announced in the new Tobacco Control Action Plan *A Breath of Fresh Air for Scotland* will allow further expansion and targeting of services to where they are most needed.

I welcome the timely publication of the *Smoking Cessation Guidelines for Scotland: 2004 Update* and the companion desktop guide, *Encouraging Smokers to Stop: What you can do*. They provide up-to-date evidence on effective smoking cessation interventions and practical guidance on the planning and delivery of smoking cessation services. Implementation of the recommendations will ensure that all health and related professionals can play an effective role and maximise the effectiveness of the specialist smoking cessation services in Scotland.

Reducing smoking prevalence is the key to improving people's health and reducing health inequalities in Scotland and the development of smoking cessation services is part of an integrated, national programme of action that will contribute to this. Much has already been achieved in helping smokers to quit but much more still needs to be done. *The Smoking Cessation Guidelines for Scotland: 2004 Update* provides the basis for service development over the next three years and is essential reading for all involved in the planning, commissioning and delivery of specialist smoking cessation services, as well as health and related professionals who come into contact with smokers during the course of their daily work.



Tom McCabe
Deputy Minister for Health & Community Care

Purpose of the Updated Guidelines

Following the publication of the White Paper, *Smoking Kills* in 1998 (1), smoking cessation services have been developed across the UK offering specialist support by trained, dedicated staff to people who need help to stop smoking. The type of service and the interventions offered vary across the country, reflecting, *inter alia*, the density of the population, the resources available, and the knowledge and experience of the staff involved.

This document was commissioned by Health Scotland and ASH Scotland to take account of the experience of the first few years of delivering these services, and recent developments in the evidence base in smoking cessation. It replaces the document *Smoking Cessation Guidelines for Scotland* published in 2000.

This updated document makes recommendations for the organisation and implementation of clinical interventions to promote smoking cessation in Scotland. It is intended for the use of health professionals and health planners at all levels. It provides a blueprint for the development of systems for ensuring that all health professionals are able to play an effective role.

The document does not consider the issue of preventing young people from starting smoking. Nor does it examine the role of fiscal and legislative interventions, both of which are central to any strategy to reduce smoking prevalence. Smoking cessation services complement such interventions and it is therefore important that these services are integrated with broader tobacco control initiatives.

This document is complemented by a short desktop guide, *Encouraging Smokers to Stop: What You Can Do*, which has been designed for busy health professionals as an easy-to-follow guide to raising the issue of smoking and giving appropriate advice. For copies of the short guide please contact your local health promotion department. Both resources can be downloaded from the web at www.healthscotland.com/tobacco.

The recommendations in these guidelines will be reviewed in September 2007.

Summary of Recommendations

This section summarises key recommendations for health professionals and organisations involved in smoking cessation in Scotland.

Recommendations 1 and 2 reflect a change in emphasis from a 'stepped care' approach (offering a progressively more intensive set of interventions) to brief advice to stop followed by a referral to the NHS Scotland smoking cessation services. These services offer specialist support to stop and the greatest likelihood of successfully stopping.

Recommendations

1. Healthcare professionals should have ready access to information on the current smoking status of their patients and should ensure that smokers have been advised to stop at appropriate opportunities and have been offered treatment to help them do so (as per Recommendation 2 onwards).

2. All smokers making an attempt to stop should have ready access to, and be strongly encouraged to use, dedicated smoking cessation services involving structured behavioural support and nicotine replacement therapy or bupropion (Zyban®).

3. Specific populations of NHS patients, such as hospital in-patients and pregnant smokers, should, as far as possible, be offered smoking cessation treatment appropriate to their circumstances at locations and schedules to suit them (see also Recommendation 5).

4. Where practicable, smoking cessation services should offer outreach to non-NHS locations such as workplaces and prisons.

5. NHS Boards should ensure that a board-wide smoking cessation service (or services) of sufficient scale and organisation to meet the needs of the population and the geography of the area is provided. Services should be provided with stable funding as a core part of NHS Scotland provision, under the direction of full-time-equivalent NHS Board smoking cessation co-ordinators.

6. Organisations and agencies in the health service should all have clearly defined roles in relation to the funding, promotion and provision of smoking cessation services with overall co-ordination at an NHS Board level.

7. Relevant NHS staff and health and related professionals in local authorities and the voluntary sector should be provided with training. This should be in line with the *Standards for Smoking Cessation Training in Scotland* and appropriate to their role in cessation, whether it be the provision of brief advice or specialist cessation support.

8. NHS smoking cessation activities should be monitored using a minimum set of indices, and figures should be reported annually to key stakeholders.

9. Other smoking cessation interventions such as No Smoking Day and Smokeline should be used where appropriate to support the NHS smoking cessation effort.

10. Research is needed as a matter of priority into:
a) methods of encouraging more smokers to use the effective treatments that are available
b) the delivery of effective treatments to special groups such as pregnant smokers and psychiatric patients
c) what constitutes best practice in the delivery of support by the smoking cessation services
d) the implications of cannabis use for smoking cessation.

Glossary

Brief advice to stop smoking from a GP or other health professional involves opportunistic advice to smokers to stop and recommendation to use treatment, e.g. the NHS Scotland Smoking Cessation Service, to help them to do so. This advice should normally take less than three minutes. It does not in itself involve help with stopping.

Specialist smoking cessation services (SCSs) offer both structured, face-to-face behavioural support and nicotine replacement therapy and/or bupropion to smokers intending to stop, by specially trained staff employed for the purpose (not by non-specialist health professionals as part of their routine care). The support can be offered in groups or individually and follows a structured protocol.

Non-specialist health professionals are staff who have not been trained to deliver specialist smoking cessation support and who are not employed for that purpose.

A **Patient Group Direction (PGD)** is a written direction about the supply and/or administration of a prescription only medicine (POM) to a pre-specified group of people.

NHS Board smoking cessation co-ordinators have a co-ordinating role for the SCSs across their NHS Board area. Health or healthcare professionals include health professionals based in local authorities and the voluntary sector as well as the NHS.

Background

Early development of the services

The White Paper, *Smoking Kills*, published in 1998 (1), sets out a national smoking cessation strategy for the UK involving the provision of NHS Scotland smoking cessation services (SCSs). In 1999/2000, £3m over three years was allocated to Scottish NHS Boards for the development of these services and the provision of nicotine replacement therapy (NRT), to be targeted particularly at areas of economic deprivation.

In 1999, the Scottish Executive reiterated the commitment to reducing smoking in its White Paper on Health, which set new targets for the reduction in smoking prevalence in Scotland (2). Targets were set for reducing adult smoking (from 35% in 1995, to 33% in 2005 and 31% in 2010), smoking prevalence among 12-15 year olds (from 14% in 1995, to 12% in 2005 and 11% in 2010), and smoking in pregnancy (from 29% in 1995, to 23% in 2005 and 20% in 2010). A commitment was given to the provision of smoking cessation treatment as part of a comprehensive tobacco control strategy. Smoking cessation was also identified as a priority for investment under the new Health Improvement Fund (HIF), which invested an additional £100m from tax revenues over a four-year period for improvements in public health.

As a result, there was a rapid development of services that were already oversubscribed. An estimated 7,000 to 10,000 smokers used the new services in 2000 (3).

Guidance for services

Guidance was provided by the Scottish Office Health Department on the provision of SCSs (NHS MEL (1999) 38). In addition, in 2000, ASH Scotland and the former Health Education Board for Scotland (HEBS) published *Smoking Cessation Guidelines for Scotland* which offered guidance on how professionals within NHS Scotland could encourage and support smokers to stop (4). The guidelines stated the need for smoking cessation interventions to be integrated into routine clinical care and for the SCSs to receive dedicated funds. A smaller guide for health professionals, *Helping Smokers to Stop — and Stay Stopped*, was produced, together with a flow chart for health professionals to guide them when intervening with smokers. A magazine for smokers, *ASPIRE to Stop Smoking*, containing helpful tips and advice on stopping, was also produced.

The Scottish Executive published further guidance on NHS smoking cessation services in August 2001 (NHS Circular: HDL (2001) 64) following an information-gathering exercise from NHS Boards (5). The Executive acknowledged the development of the services but commented that their availability varied widely across the country. Most boards had developed services targeted at the White Paper priority groups (pregnant women, young people and people living in deprived areas). The Scottish Executive report identified a number of gaps in the services, although boards had indicated that they intended to extend the services to fill these gaps in the future. At that time not all boards had a dedicated smoking cessation co-ordinator. The Executive indicated that the £1m per annum for SCSs allocated after *Smoking Kills* would now be included in NHS Boards' unified budgets and would therefore continue to be available. In addition to this and the HIF monies, NHS Boards could also use funding from the Revenue Allocations.

Recent strategies and initiatives

Other government strategies have emphasised the importance of helping people to stop smoking. *Cancer in Scotland: Action for Change*, published in 2001, stressed the role of smoking in causing cancer and highlighted the need to help low-income smokers in particular (6). *The Coronary Heart Disease and Stroke Strategy for Scotland* published in 2002 emphasised the importance of reducing smoking as it was a major preventable cause of CHD and stroke (7).

In 2002, Partnership Action on Tobacco and Health (PATH) was established. Funded by the Scottish Executive for three years and managed by ASH Scotland, PATH was set up to support the implementation of the Government's tobacco control policies. This includes the development of national training standards, managing a fund of £300,000 per annum for three years to provide support for local initiatives in smoking cessation and prevention work, and contributing towards a systematic process for evaluating the SCSs.

In addition, in 2002 the Health Technology Board for Scotland (now part of NHS Quality Improvement Scotland) advised that the guidance on NRT and bupropion published by the National Institute for Clinical Excellence (NICE) in England and Wales was valid for Scotland (8). This guidance concluded that NRT and bupropion were among the most cost effective of all healthcare interventions and should be recommended to smokers who expressed a desire to quit.

More recently, Health Scotland and ASH Scotland have emphasised the need to reduce smoking as a means of transforming Scotland's health (3) and have recommended a comprehensive, sustained, national tobacco control strategy to achieve this. A series of recommendations was made including the need for long-term funding of SCSs. The former Health Education Board for Scotland and ASH Scotland have also initiated a national programme of eight pilot SCSs aimed at young smokers who want to stop (see Appendix 1). These are currently being evaluated.

In March 2003, the Scottish Executive set out a strategy for action to improve the public health of the people of Scotland in the form of a Challenge (9). This identified tackling smoking as a key factor and indicated that a review of national tobacco control policy would be carried out imminently, resulting in a new plan for action that would build upon achievements to date.

The new Tobacco Control Action Plan, *A Breath of Fresh Air for Scotland*, was published in January 2004 (10). The Plan sets out measures designed to reduce smoking and tobacco-related harm. These include the upgrading of the existing Scottish Executive Tobacco Control Strategy Group to a Ministerial Working Group to ensure effective implementation of the plan and, with specific relevance to smoking cessation, an additional £7 million for SCSs over three years. This brings the total investment in SCSs to £3 million for both 2003/04 and 2004/05, rising to £7 million in 2005/06.

The Plan also sets a new national target for adult (16-64) smoking prevalence of 29% by 2010, and gave an undertaking to agree interim local cessation targets with NHS Boards in 2004. National smoking prevalence targets for young people and pregnant smokers will be reviewed in 2005.

Current services

By the start of 2003, it appeared that all areas in Scotland had a smoking cessation co-ordinator and at least one SCS. A range of models of service delivery operates, with accessibility varying widely across the country. Some of the SCSs have been integrated into primary and secondary care.

The NHS Board smoking cessation co-ordinators belong to a Smoking Cessation Co-ordinators' Group which was established by the Scottish Tobacco Control Alliance (STCA), a multi-disciplinary, multi-sectoral body of over 130 organisations, set up by ASH Scotland in 2001. The Smoking Cessation Co-ordinators' Group has since been replaced by the Tobacco Control Issues Group.

The current guidance was commissioned by Health Scotland and ASH Scotland to take account of recent developments in the evidence-base in smoking cessation and the experience of the first few years of setting up and delivering SCSs across the UK.

Recommendations and Evidence

This section describes the recommendations in detail. The main recommendation is given first, followed by more detailed recommendations.

Where the recommendations relate to issues that have been subjected to rigorous scientific investigation they are followed by supporting evidence and a note on 'best practice' which uses experience from existing smoking cessation services (SCSs) to suggest ways of implementing the recommendations.

These recommendations are classified by strength of evidence as follows:

(A) Strong supporting evidence from more than one controlled trial

(B) Moderate supporting evidence from one controlled trial and/or descriptive studies

(C) Weak supporting evidence based on descriptive studies or pilot studies

Where recommendations are based on an analysis of the management issues involved in delivery of smoking cessation interventions or experience from existing services they are followed by a section called 'Rationale and best practice'. No strength of evidence label is applied to these recommendations.

Case studies are also used to illustrate some of the issues discussed in the text. The information on SCSs has been provided by the smoking cessation co-ordinators (unless otherwise stated) and has been only minimally edited.

Recommendation 1

Healthcare professionals should have ready access to information on the current smoking status of their patients and should ensure that smokers have been advised to stop at appropriate opportunities and have been offered treatment to help them do so (as per Recommendation 2 onwards).

1.1 GPs should ensure that they have discussed smoking with known smokers at least once a year, and advised them to stop and offered treatment (in the form of a referral[1] to an NHS Scotland SCS as the preferred option) to help them do so. **(A)**

1.2 Hospital doctors, dentists, midwives, health visitors and other health professionals should advise patients to stop on initially determining their smoking status, offer treatment to help them do so and possibly repeat this at appropriate opportunities thereafter. **(A)**

1.3 All records held in General Practice and hospitals should contain information on a) current smoking status, b) most recent occasion on which advice was given to stop, and c) response to that advice (see Figure 2, page 15). **(A)**

1.4 In practices where General Practice Administration System for Scotland (GPASS) is used, GPs should complete the smoking screens for all patients who smoke.

1.5 ISD Data Standard Groups/GPASS should adapt their record of smoking status and associated Read Codes to include recent ex-smokers so that progress with their quit attempts can be monitored and further advice and support given as appropriate.

Evidence

There is strong evidence that brief advice to stop smoking from a GP (normally taking less than three minutes), given to all known smokers in the course of a consultation, leads 1-3% (best estimate 2%) to stop for at least six months. This is over and above those who would have stopped anyway (11). The effect is independent of age, gender and whether or not the smoker is suffering from a smoking-related disease.

Ten hours of brief advice, spread over 200 40-year-old healthy smokers, will help between one and two smokers to stop, on average, about 25 years earlier than they would otherwise have done, gaining an aggregate of some 5.75 years of life[2]. The estimated cost per life year gained can be estimated at £182 without discounting[3]. For older smokers, or smokers who already have smoking-related diseases, the health gains are less but in most cases they still emerge at under £1000 per life year gained. The median cost per life year gained of other life-saving medical interventions has been put at about US$19,000 (12), so brief advice represents excellent value for money as a life-preserving intervention.

It is impracticable, and may be counter-productive, for GPs to advise smokers to stop more than about once a year (13).

The new GP contract makes repeated reference to smoking issues in both the clinical and administrative domains and 87 quality points are specifically attributed to smoking. These quality points are achieved by demonstrating that smoking status is recorded and smoking cessation

1 Which may be a formal referral or agreement that they will contact the service

2 Taking the lower bound estimate of the effect of brief GP advice (1% abstinent for six months), recognising that about 10% of those who stop in response to GP advice will relapse each year and that up to 2% of smokers who do not receive such advice will stop anyway

3 Discounting is an economic device which reduces the value of a benefit such as life-years gained the further in the future it is

advice has been given for smokers with any of the 8 of the 10 chronic diseases. However, the importance of documenting the smoking status of all patients is also highlighted in the contract.

To achieve maximum quality points, practices must take into account 'holistic care' and 'quality practice' achievement. In total, smoking issues account for over 104 points (out of the maximum 1050 points) and therefore make up nearly 10% of the entire quality framework (14).

Studies have shown brief advice from hospital physicians to be similarly effective but the circumstances in which that advice can be delivered are generally different (11). Hospital physicians are often involved in treating an acute illness or managing a specific chronic condition such as chronic obstructive airways disease. In these circumstances, practicalities dictate that advice should be given early in the treatment process and possibly repeated at intervals as circumstances allow.

Given the health risks of smoking in pregnancy, it is particularly important that GPs, midwives and other health professionals advise pregnant smokers to stop and refer them to the NHS SCSs (see over). A fast track referral system should be in place for pregnant smokers so that they can be contacted quickly by specialist staff.

The studies to date have shown only hospital physician or GP advice to be effective. There is no evidence as yet for the effectiveness of brief advice given by other health professionals. It is therefore important that hospital physicians and GPs continue to undertake this role. However, all health professionals can play a role in encouraging smokers to stop and, more importantly, in promoting the use of NHS SCSs.

Best practice

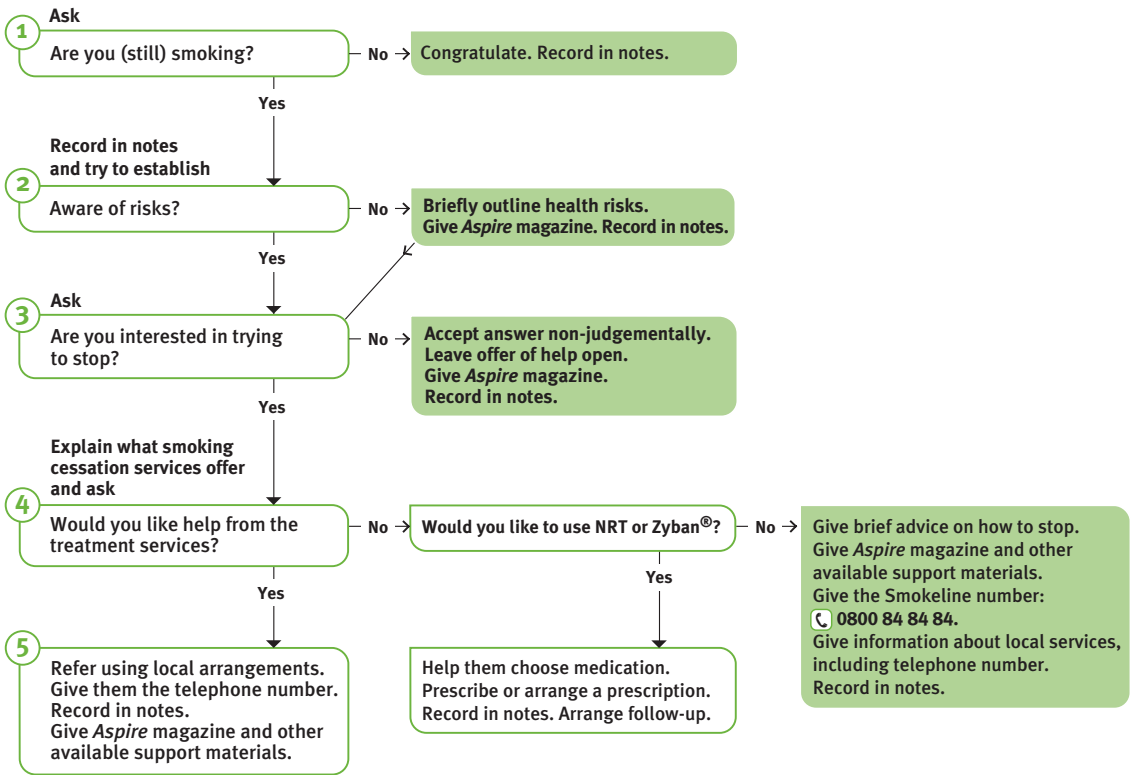
The research on brief advice was conducted mostly at a time when smokers would have had little or no support to aid their quit attempt. This situation has now changed and the more smokers can be encouraged to use the SCSs, the greater will be the effect of the advice. However, it also has to be recognised that many smokers want to try to stop with limited help or no help at all. It is worth spending some time trying to persuade smokers to use the most intensive form of help they are willing to accept. Figure 1 (over) gives a proposed flow chart for the delivery of brief advice in a routine consultation.

If the smoker is unwilling or unable to attend the SCS, they should be offered a prescription for NRT or bupropion (see Figure 1, over).

It would be useful if GPs have a simple information sheet to give to smokers explaining what the local NHS SCS can provide and how such support will help increase the chances of stopping successfully.

Research with GPs shows that they feel most comfortable providing advice on smoking to patients with smoking-related diseases (15). The fact that similar results can be achieved with all patients groups means that it is important not to restrict advice to patients with smoking-related diseases. In fact, the greatest health gains are achieved by leading a young healthy smoker to stop before onset of smoking-related conditions. However, the advice can be personalised to patients' current health conditions.

Figure 1: Flow chart for brief advice to smokers



The flow chart illustrates a change in emphasis from the stepped care approach (offering a progressively more intensive set of interventions) to brief advice to stop followed by a referral to the NHS SCSs which offer relatively intensive support to stop and the greatest likelihood of successful stopping.

Many computerised patient record systems now have smoking information included. However, the way it is recorded is variable and not always very useful. A simple and effective system is given in Figure 2.

Smokers and recent ex-smokers should have a trigger on the database which indicates if more than a year has elapsed since status was last checked.

GPASS is the most commonly used patient record system in Scotland, with information on smoking recorded via the chronic disease screens (contract items). Smoking status for all patients can also be recorded on the basic values screen. However, more detailed information on smoking can be recorded for all patients via the smoking screens and we recommend that GPs should complete these for all patients who smoke. For details of GPASS screens see Appendix 2.

We also recommend that the current GPASS Read Codes should be adapted to reflect the system outlined in Figure 2, to enable GPs to identify recent ex-smokers so that progress with their quit attempt can be monitored and further advice and support provided as necessary. Given the possibility of relapse among recent ex-smokers, this is also necessary to prevent the assumption from that point on that these patients are non-smokers.

Figure 2: A system for recording smoking information

Smoking status	Smoker Recent ex-smoker (<1 year) Long-term ex-smoker Never smoker
Date advice last given	
Response to advice	Not interested Wants to stop but not at the moment Intends to stop now but help not wanted Intends to stop now and wants medication Intends to stop now; will attend smoking cessation service Not applicable

Recommendation 2

All smokers making an attempt to stop should have ready access to, and be strongly encouraged to use, dedicated SCSs involving structured behavioural support and nicotine replacement therapy (NRT) or bupropion (Zyban®).

2.1 SCSs should offer both structured face-to-face behavioural support and medication (see below) to smokers intending to stop, by specially trained staff employed for the purpose (not by health professionals as part of their routine care). **(A)**

2.2 The behavioural support should involve multiple sessions starting at least one week before a set quit date and continuing for at least four weeks afterwards, generally on a weekly basis. **(B)**

2.3 The behavioural support should use a structured protocol to ensure that all aspects of motivational and medication advice are delivered. **(B)**

2.4 Smokers should be strongly recommended to use NRT or bupropion, accompanied by appropriate support and advice, unless contraindicated, and an NHS prescription should be routinely offered. **(A)**

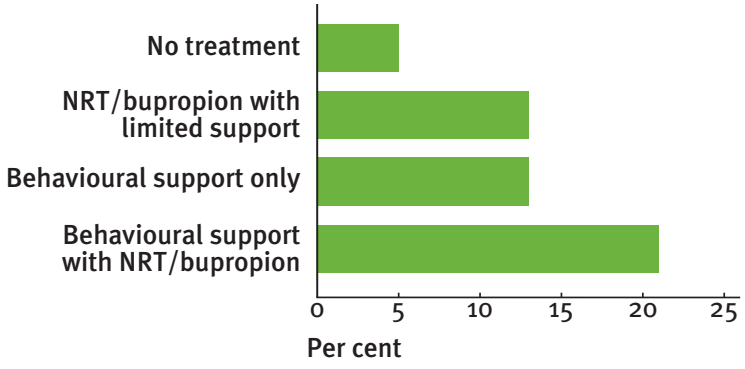
2.5 Where practicable, the SCSs should include both group and individual treatment options for their clients. **(B)**

2.6 Behavioural support to aid cessation[4] should not take the form of brief interventions delivered by non-specialist staff as this has been shown to be ineffective[5]. **(A)**

Evidence

Face-to-face behavioural support can lead an estimated 8% of smokers receiving it to stop for at least six months (16). Adding NRT or bupropion to the behavioural support increases six-month success rates on average by 8-9% (17). Thus the combined effect on six-month abstinence rates of behavioural support and NRT or bupropion is 16-17% (Figure 3). Added to the chances of success without treatment (approximately 5%), this takes the overall chances of quitting to more than 20% for smokers receiving both medication and behavioural support. In some rural/island areas, face-to-face support may not always be feasible. Alternative approaches such as video conferencing or proactive telephone support have been used but such methods are unlikely to give the same success rates.

Figure 3: Approximate percentage of quit attempts achieving at least six months of continuous abstinence as a function of treatment



4 As opposed to triggering a quit attempt

5 Brief interventions by non-specialist staff (staff who have not been trained to deliver specialist smoking cessation support and who are not employed for that purpose) are effective in triggering a quit attempt and encouraging smokers to use the SCS but are not a substitute for that service

These figures assume that the smokers are motivated to stop smoking, that the behavioural support is provided by specially trained staff (specialist staff) employed for the purpose and that the programme of support is structured and follows a clearly laid out protocol.

The combined treatment option (behavioural support together with NRT or bupropion) is the treatment of choice. The relapse rate is no more than 10% per year (18) and the natural cessation rate in this group of smokers is also very low (less than 2% per year) so the combined treatment can be expected to translate into at least 12% stopping on average 25 years before they would otherwise have done.

If eight smokers each receive two hours of treatment (16 hours in combination) then this will help one of the eight smokers to stop on average about 25 years earlier than he or she would otherwise have done gaining an estimated 5.75 years of life (if stopping at age 40). Taking into consideration the administration costs, infrastructure costs, medication and other costs, the estimated cost per life year gained is estimated at £203 without discounting. For older smokers or smokers with smoking-related diseases, the increase in life expectancy is less but in most cases it remains at under £1000 (19).

Evidence comparing frequency and duration of contact across studies has shown a consistent, positive association with success rates (20).

Where a structured protocol has been compared with an informal approach, the former has been found to be more effective (21).

Whereas one study that compared a nicotine patch with bupropion found the latter to be more effective (22), it is considered that this is insufficient evidence to recommend bupropion over NRT. The overall effect size for bupropion is very similar to that for NRT in comparable studies (8). Thus both are considered first-line treatments.

Concerns have been expressed in the media over the safety of bupropion. However, the evidence is clear that it has a similar safety profile to modern antidepressant drugs that are generally considered safe (8). The Summary of Product Characteristics for bupropion declares a seizure risk of 1 in 1000 but this can be mitigated by ensuring that patients are carefully screened for pre-disposing factors (23). Common side-effects are insomnia and dry mouth but these are rarely serious enough for patients to discontinue treatment.

There is insufficient evidence to state with confidence whether group treatment is more successful than individual treatment (24), but studies with groups have shown high success rates and early evidence from the English SCSs indicates that group treatment was associated with higher four-week self-reported cessation rates (25). Not all patients will be suitable for group treatment, so individual treatment should also be available. Individual treatment will also be most appropriate where the local population is spread over a large area.

There has been some debate over whether NRT or bupropion provided without behavioural support from an SCS can be effective. With regard to NRT, there is evidence that the patch and gum can still be effective with limited support, increasing six-month continuous abstinence rates by an estimated 5-10% (26). With regard to bupropion, the success rates observed in smokers who use only the telephone helpline provided appears to be similar to that found in smokers receiving face-to-face behavioural support (27). Therefore, while the treatment of choice is behavioural support plus medication, medication plus more limited support can also be beneficial and may be acceptable to a larger number of smokers.

Several studies in different patient populations have examined whether routine healthcare staff can deliver effective behavioural support for smoking cessation attempts as part of their normal duties and none has found a positive effect (28). Successful treatment for nicotine dependence requires a more intensive and expert intervention than can normally be delivered as part of routine care.

SCSs would be advised not to offer the following treatments on the NHS because of insufficient evidence of specific efficacy: acupuncture (29), hypnotherapy (30), lobeline (24), silver acetate (16), opioid antagonists such as naltrexone (31) and anxiolytics such as benzodiazepines (32). Although clonidine has been shown to be effective in some studies, prominent side-effects probably make it inappropriate as a first-line treatment (33). Other methods such as laser therapy that have not been evaluated scientifically should not generally be offered on the NHS. Aversive smoking treatments, including 'rapid smoking' have not been adequately evaluated and should not be offered until and unless well-controlled studies of adequate power show an effect (34).

Best practice

Figure 4 opposite shows a typical treatment programme. The following text explains the items in the diagram.

At assessment it is essential to check that the smoker is motivated to stop in the next week or two and that he or she is willing and able to attend all the sessions. Dependence is assessed, usually by means of the Fagerstrom test for Nicotine Dependence (FTND) (35). This can help to guide choice of medication and assess prognosis. Expired air carbon monoxide (CO) should be measured to enhance the smoker's motivation to succeed at this quit attempt.

The explanation of the treatment plan should create realistic and positive expectations and describe the 'active ingredients' of the treatment which are a) structuring the quit attempt, b) ensuring that it is adequately prepared, c) using social support to enhance motivation to succeed, d) providing guidance on avoiding and coping with urges to smoke, e) providing reassurance and advice on withdrawal symptoms, and f) guidance on correct use of the medication.

Suitability for medication can be assessed by means of a few simple questions. If a smoker arrives with a clear preference for one form of medication it is reasonable to offer that medication to the smoker unless it is contraindicated. Otherwise, we recommend checking for contra-indications to all the products and offering the patient a choice between the ones that are permitted. Treatment with bupropion begins one week before the quit date.

Creating positive but realistic expectations is designed to capitalise on survey evidence that smokers with greater confidence in success are more likely to remain abstinent. Smokers can be informed that the treatment plan will quadruple their chances of success.

It is believed that social factors play an important role in behavioural support. In the case of individual counselling, the rapport between the specialist and the smoker can act as an important barrier to relapse; the smoker does not want to let the specialist down. In group treatment programmes, smokers report that the need not to let the group down is important. There are various methods of maximising these influences.

Preparations for the quit date typically include advising smokers not to make a deliberate effort to cut down or stop before that date and to have the last cigarette just before the quit date session. It is also advised that smokers plan to minimise temptation during the first week after the quit date by discarding smoking materials and reminders of smoking, telling friends, family and work colleagues of the quit attempt and preparing mentally for the 'not a puff' goal.

Figure 4: Structure of a typical smoking cessation programme

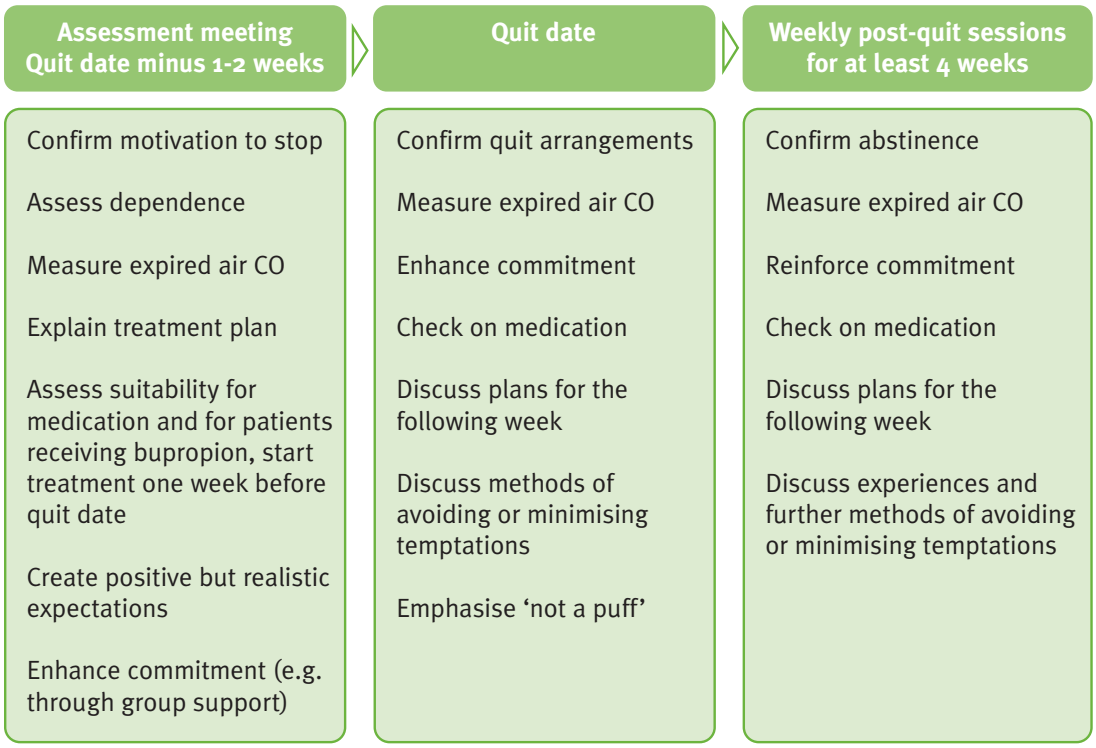


Figure 4 shows that on the quit date, many of these messages are reinforced. The smoker can also be prepared for the likelihood that he or she will experience mood disturbance and other withdrawal symptoms, on the principle that 'forewarned is forearmed'.

At the one week post quit-date session and all subsequent sessions, the smoker's expired air CO will be less than 10 parts per million if he or she has maintained abstinence. Smokers report finding the change highly rewarding. Providing strong social reinforcement for abstinence is a key element of this and subsequent sessions. At the final session, preparations need to be made for clients to continue with their medication (at least for 8-10 weeks of medication in total, as appropriate, see below) and for follow-up at 3 and 12 months.

Medication issues

The cost-effectiveness of NRT and bupropion was emphasisd in the NICE assessment of these treatments (8).

Patient Group Directions (PGDs) can be used to ensure efficient and expert provision of smoking cessation medications to clients of the SCS. A PGD is a written direction about the supply and/or administration of a prescription only medicine (POM) to a pre-specified group of people. It also permits the supply or administration of POMs on the NHS by health professionals who are not 'independent prescribers' or are working in situations where the proposals for 'supplementary' prescribing do not cover all patient scenarios. A PGD also allows for medicines to be supplied outside the terms of the product licences. The UK charity PharmacyHealthLink (formerly the Pharmacy Healthcare Scheme) has produced a manual explaining how to set up these arrangements including templates for both NRT and bupropion (23). The manual also includes

advice for supplying NRT through PGDs for pregnant smokers, young smokers and smokers with cardiovascular disease (CVD). The manual was endorsed by 12 organisations including the Royal College of General Practitioners, Royal College of Nursing, Royal College of Physicians and the Royal Pharmaceutical Society of Great Britain.

NRT and bupropion should be provided to meet clinical need in accordance with NICE Guidance (8) that has been endorsed as valid for Scotland by NHS Quality Improvement Scotland guidance.

There is no scientific basis for preferring one form of NRT over others except that 4mg gum has been found to be more effective than 2mg gum in more dependent smokers (17). The choice of product should be based on anticipated sensitivity to side-effects of particular products (e.g. difficulty chewing gum or sensitive skin) and client preference.

There is no scientific basis for not allowing different forms of NRT to be combined and there may be some benefit to combinations. Most commonly, a combination of an acute dosing form of NRT such as the nasal spray or the inhalator with the patch is used.

No recommendation can currently be made concerning the circumstances in which bupropion should be preferred over NRT or vice versa, other than those for which one of the drugs is contra-indicated. The evidence to date suggests that having previously used NRT does not undermine the effectiveness of NRT in the current quit attempt (36).

Both NRT and bupropion should be prescribed for relatively short durations at a time and the prescriptions repeated only if the quit attempt is continuing. This avoids a potentially large wastage of medication in quit attempts that do not last beyond a week or two. It is recommended that the supply of the prescribed medication is sufficient to last only two weeks after the target quit date. For NRT this would normally be two weeks with a second or subsequent prescription(s) offered only if the smoker demonstrates a continuing quit attempt. With patches, the final prescription involves tapering of the dose, although research has found no benefit for tapering the patch dose versus abrupt cessation after eight weeks on the full dose (37). For bupropion, the recommended prescribing interval is four weeks and then four weeks.

Mechanisms should be put in place (such as the use of PGDs) to ensure that the full supply of the medications can be accessed through the service, without the need to make repeated visits to the GP. PGDs can be particularly useful in rural areas, the highlands and the islands.

NHS DUMFRIES & GALLOWAY

Smoking Matters

This case study is of a specialist service within primary care and also illustrates the use of a Patient Group Direction (PGD).

Catchment
Mixed — urban/rural and deprived/affluent

Setting
Primary care-based specialist cessation service

Service Description
Smoking Matters is a specialist cessation service within primary care. Clients can be referred to the service only by a member of the primary care team. Clients who are referred are offered approximately six to eight appointments, dependent on need, and up to three months' supply of NRT, which is issued to the client via a PGD at two-weekly intervals.

The PGD for NRT has with it a notional fixed sum of £60K per annum which is managed by Smoking Matters. This PGD was agreed with the Area Drugs and Therapeutics Committee and uses money that would have been spent within the existing Primary Care Prescribing Budget.

As the referral process is through primary care only, a clinical decision is made before referral as to whether NRT is suitable for a particular patient. The PGD does not include bupropion.

The PGD has operated for over two years and it is likely that the current system will continue with some slight modifications, including an increase in the notional amount.

There has been some interest in examining what provision can be made for the most heavily dependent smokers. It would seem reasonable to propose that these smokers receive more intensive and prolonged behavioural support and/or higher doses of NRT or combinations of NRTs. However, as yet there are no clinical trials on which to base recommendations.

Recommendation 3

Specific populations of NHS patients, such as hospital in-patients and pregnant smokers, should, as far as possible, be offered smoking cessation treatment appropriate to their circumstances at locations and schedules to suit them (see also Recommendation 5).

3.1 **Pregnant smokers** should, as far as possible, be offered structured, face-to-face, one-to-one behavioural support at locations and schedules to suit them. **(A)**

3.2 NHS Board **smoking cessation co-ordinators** should build relationships with maternity services to ensure timely referral of pregnant smokers to intensive support. A specific strategy will need to be developed, organised locally, ideally with one or more designated posts. In general, post-holders should be midwives. **(C)**

3.3 **Young smokers** (under the age of 16) who express a desire for smoking cessation treatment may be offered face-to-face behavioural support. The use of NRT to support the quit attempt should be fully discussed and NRT should be provided if requested by young smokers showing evidence of nicotine dependence. **(C)**

3.4 **Low-income smokers** are an important target for the services. NHS Board smoking cessation co-ordinators need to ensure services are reaching and effectively supporting low-income smokers to quit. **(C)**

3.5 **Smokers about to go into hospital** should receive clear advice to stop smoking by a clinician. The advice should present the increased surgical and anaesthetic risks that smokers run and be accompanied by strong encouragement to attend the SCS before admission. **(B)**

3.6 **Hospital in-patients** who smoke should be routinely offered structured behavioural support and medication during their stay and continued support by the SCS on discharge. **(A)**

3.7 **Psychiatric patients** and patients with enduring mental health problems who smoke should be offered structured behavioural support and NRT (or bupropion if not contra-indicated) from the SCS. The treatment package should be tailored to the needs of these patients. **(C)**

3.8 **Smokers with CVD** (including those undergoing cardiac rehabilitation) should be strongly encouraged to attend the SCS for behavioural support and NRT or bupropion (Zyban®). **(B)**

3.9 **Smokers attending out-patient chest clinics** should be encouraged to attend the SCS for behavioural support and NRT or bupropion. **(B)**

3.10 **Diabetic smokers** should be encouraged to attend the SCS for behavioural support and NRT or bupropion. **(B)**

Some of these groups are at a high risk of suffering health consequences as a result of continuing smoking and present a particular challenge to practitioners where the evidence base is still developing or is not yet clear cut. The research and following case studies are intended to provide support for clinicians, particularly in relation to NRT, where some fear the threat of litigation if they act against current NRT licensed indications.

For a discussion of older smokers see page 30.

Pregnant smokers

Evidence

Cigarette smoking is the single largest modifiable risk factor for pregnancy-related morbidity and mortality (38) and is a major cause of health inequalities. The importance of smoking cessation in pregnancy and in the early neonatal period has been emphasised in other guidance, for example, in the management of asthma (39).

All pregnant smokers should be advised of the dangers of smoking to the foetus and themselves and be advised to stop smoking. This information must be given at the earliest possible opportunity in the pregnancy, either by the GP or midwife. One opportunity to advise smokers is when smoking status is routinely recorded at first clinic booking through SMRO2. The advice given and response received should also be recorded, as well as smoking in the 12 months prior to conception and smoking status at the time of delivery. This additional information can be recorded through the Scottish Women's Maternity Record (SWMR), currently being developed by Quality Improvement Scotland. Referrals should then be made to the specialist services, as trials have shown that midwives providing behavioural support as part of routine consultations have no effect (38).

Studies have shown that about 1 in 15 pregnant smokers (who would not otherwise have done so) will stop smoking for the remainder of the pregnancy when given specialist support (38). Such support is unlikely to be taken up by the majority of pregnant smokers (40), but uptake rates may improve if the support is offered in a convenient location for the mother, such as the home (see 'Best practice' below). A recent trial of self-help materials alone, implemented during routine antenatal care, found them acceptable but ineffective (41).

Best practice

Those who do not want face-to-face, behavioural support should be offered telephone counselling (Smokeline) because there is some evidence, although not in this patient group, that proactive telephone counselling can be effective (42).

The NICE guidance, endorsed as valid for Scotland by the Health Technology Board for Scotland (now part of Quality Improvement Scotland), advised that the use of NRT in pregnancy was appropriate, providing a discussion of the risks/benefits had taken place with the woman concerned. One of the key risk factors to assess is the likelihood of the woman continuing to smoke without the use of NRT. Advising in favour of the use of NRT only after attempts to stop have failed without NRT may risk continued smoking throughout the pregnancy, as motivation to quit may be diminished by a failed quit attempt.

The use of NRT to support the quit attempt should be fully discussed and information provided if requested. Although there are some concerns about the safety of nicotine in pregnancy, the risks of smoking in pregnancy can be expected to outweigh the risks of NRT in pregnancy (43), so NRT should be considered for use if it can improve a pregnant smoker's chances of stopping. One placebo-controlled trial of nicotine patches in pregnancy did not find a significant effect on smoking cessation, although the women allocated nicotine patches had significantly higher birth weight babies than the women allocated placebo patches (44).

Advice on NRT and pregnant smokers has recently been changed in the British National Formulary (BNF) Number 46 to reflect the NICE guidance (45). Pregnancy is no longer listed as a contraindication for NRT. The BNF states:

'Use only if smoking cessation without nicotine replacement fails; avoid liquorice-flavoured nicotine products; patient information for some products contraindicates use.'

As regards breastfeeding, we recommend the use of NRT for smoking cessation for women who breastfeed. The dose of nicotine delivered in breast milk from NRT will be very small, the risk to the baby is minimal and the benefit of a smoke-free environment is large.

It will take some time for these changes to be made to the individual NRT product licences, but it is worth co-ordinators bringing this change to the attention of local GPs and hospital physicians who may be reluctant to prescribe NRT to pregnant women. Co-ordinators may also still draw up a PGD to cover the use of NRT in pregnancy locally, as the PGD gives advice and helpful information for prescribers. A PGD will also enable midwives to supply NRT to pregnant women.

Although some experts have suggested it would be prudent to use the shorter-action nicotine delivery systems, such as the gum or lozenge, in pregnancy, because of concerns about excessive exposure to nicotine over time, others have argued that pregnant smokers are more likely to use patches than oral products because of problems with nausea and taste (23).

One case study from England has described what can be achieved with dedicated specialist staff working closely with the midwifery services (46). The particular factors associated with success in this case study appear to be: the specialist was a midwife who was employed solely to provide smoking cessation specialist support to pregnant smokers; the specialist was notified when a pregnant mother acknowledged she was a smoker at the booking appointment; treatment was offered at the smoker's home and involved one-to-one support with the offer of NRT. The PGD recently produced by the UK charity PharmacyHealthLink provides useful advice on the offer of NRT in pregnancy.

It is clear that NHS Board smoking cessation co-ordinators have a responsibility to build relationships with local maternity services to ensure timely referral of pregnant smokers for intensive specialist support. A specific strategy will be needed for each service, preferably with a designated post-holder, who should be a midwife.

NHS ARGYLL & CLYDE

CATCH (Community Action on Tobacco for Children's Health)

This case study is an example of a service based within a hospital maternity unit targeting pregnant smokers.

Catchment
Mixed — spread over four local health care co-operatives (LHCCs) in Renfrewshire and East Renfrewshire including a number of Social Inclusion Partnership (SIP) areas

Setting
Hospital maternity service

Service Description
The project is based within the maternity unit and provides a smoking cessation support service for young pregnant women (less than 25 years old) and their partners. The project team consists of the project leader/midwife and a half-time administrative assistant. Being based within the maternity services has enabled good links to be established with all health professionals working with pregnant women.

Clients of the service can self-refer through a reply-paid postal service, by telephone or email, or be referred by hospital and community-based health professionals. The project leader will arrange to meet clients at a time and location most suited to them. Partners who smoke can also be seen in this way.

An ethos of non-judgemental care and support permeates CATCH philosophy and practice. This ethos, along with the knowledge and skills in midwifery brought to the project by the project leader, supports the development of rapport with clients. While tobacco issues are the main focus of the work, the health and social care issues confronting this young population can at times take pre-eminence. This holistic approach aims to achieve both short and longer-term outcomes in health promotion and smoking cessation.

Young smokers

Evidence

Many adolescent smokers inhale cigarette smoke, show signs of nicotine dependence and have tried to quit unsuccessfully. As yet there are no controlled trials showing that behavioural support or medication are effective in helping them stop (47). However, it appears that NRT can be used safely and with reasonable compliance (48). Pilot smoking cessation interventions for young people are currently being evaluated in Scotland (see Appendix 1). The PGD recently produced by the UK charity PharmacyHealthLink provides useful advice on the offer of NRT to adolescent smokers.

Best practice

While the evidence does not support routine delivery of smoking cessation treatment for smokers under the age of 16, general principles suggest that where there is a demand it may be offered, pending the results of current research and pilot programmes.

Low-income smokers

Evidence

Smoking prevalence is much higher amongst low-income groups and there is also clear evidence of greater dependence (49). Smoking therefore accounts for a substantial part of the socio-economic variation in premature mortality (50). New research shows that the English SCSs have been successful in reaching low-income smokers and it ought to be possible to replicate this pattern in Scotland (51).

Best practice

Although this is an under-researched area, there is no evidence to suggest that SCSs will not be able to support low-income smokers in stopping. Flexibility of service delivery and accessibility of the service appear to be important (51). In addition, because of greater nicotine dependence, as a group low-income smokers may also require more intensive support from services than more affluent smokers to achieve the same quit rates.

NHS FORTH VALLEY

Smoking Cessation Service

This case study shows a service offering a flexible self-referral system to attract low-income smokers.

Catchment
Deprived

Setting
Health centres, primary care

Service Description
The service offers evening smoking cessation clinics located in known areas of deprivation. To attract smokers on low incomes, smokers can self-refer and no appointment is needed. Four weeks' free NRT is offered to those assessed as suitable, with the option of obtaining further supplies of NRT from the patient's GP.

The service offers one-to-one or group interventions and is staffed by sessional workers who work in the Forth Valley NHS Board as nurses, pharmacists, etc. They have been trained in smoking cessation and have also participated in the Maudesley smoking cessation training course in London.

Hospital patients who smoke: pre-admission patients and in-patients

Evidence

Anaesthetic risks and the risk of post-operative complications are higher in smokers than non-smokers (52). One study has found that smoking cessation treatment delivered before planned surgery can have important benefits in terms of reducing post-operative complications (52).

Studies of structured behavioural support given during a hospital in-patient stay indicate that this can improve short- and long-term cessation rates (16).

Best practice

As a matter of good workplace practice, all hospitals should be smoke-free and all patients should be advised of this at the earliest opportunity before admission. Patients should also be clearly advised, both personally by a clinician and in writing, that they should stop smoking before admission to reduce their risk of complications. The contact details of the patient's local SCS should be provided. The SCS should be configured to be able to respond quickly to requests for help from pre-admission patients.

NHS FIFE

Kirkcaldy Levenmouth LHCC Smoking Cessation Service

This case study is a good example of working in partnership with the acute sector.

Catchment
A mixed population of 98,000. There are two wider areas of regeneration within the LHCC — Kirkcaldy and Levenmouth. Within these, there are smaller areas of housing regeneration: Dysart in the Kirkcaldy area and Methil, Buckhaven and Methilhill in the Levenmouth area.

Location
Primary care

Service Description
The LHCC supports a dedicated SCS. A full-time smoking cessation worker, as well as community and practice nurses, who were given advanced training on smoking cessation, offer both one-to-one and group sessions over a seven-week programme. Thirty hours of clerical support are also built into the service. This service is provided alongside a community pharmacy smoking cessation scheme.

Smoking cessation clinics are provided in health centres and community venues throughout the locality during the day and in the evenings.

This service is co-ordinated by the LHCC senior cardiovascular nurse who has been involved in setting up secondary prevention cardiac clinics in primary care and who also participates in the managed clinical network for coronary heart disease services within Fife. This network is working towards integrating services between primary and secondary care, in a drive to improve the patient journey.

Being advertised throughout the locality, the LHCC SCS is actively promoted in the hospital setting and patients are encouraged to contact the service for continuing smoking cessation support upon discharge. The SCS has also worked closely with acute services to help them set up a smoking cessation programme for all staff. This has developed relationships and built on existing partnership working.

Local services are currently being evaluated and the LHCC is continuing to look at service development and new ways of working with partners in the health, local authority and voluntary sectors.

The provision of behavioural support to hospital in-patients, who are still smokers upon admission, is complicated by a number of factors. Patients are often too unwell to receive help, spend much time asleep or undergoing procedures, or are admitted for too short a period of time for behavioural support to be provided. For these reasons it makes sense for the SCS to establish a system whereby, on admission, the nursing staff on wards routinely ask suitable patients who smoke if they want help and contact the SCS if the response is positive. The SCS should, where possible, employ a smoking cessation specialist to cover the acute hospitals in their area, providing bedside support and medication (through the hospital pharmacy). The SCS should ensure that smokers have follow-on care when they are discharged.

Some services in Scotland offer support in acute hospitals. For example, in West Lothian, the community SCS is based in an acute hospital trust, and offers smoking cessation support to in-patients across the hospital. Another example of good practice comes from England, where one hospital uses the hospital pharmacist to identify and refer smokers to an in-patient hospital SCS, as pharmacists visit all hospital in-patients shortly after admission.

Psychiatric patients who smoke

Evidence

Psychiatric patients have very high rates of smoking, particularly those living in either hospital or community-based psychiatric institutions, where there may often be a culture of smoking. Smokers with psychiatric problems show higher levels of dependence than smokers in the general population. Many express interest in stopping but are not offered advice and support in doing so (53).

Research from other countries has shown that smoke-free policies can be implemented in psychiatric institutions, providing there is careful planning and consistent application by all staff (54).

Support for smokers wanting to stop should be made available and accessible when implementing smoke-free policies. There is some evidence from uncontrolled trials that specialist support, modified as necessary for use with smokers with mental health problems, can be effective (55) and that stopping smoking does not exacerbate the mental health condition (53) .

Best practice

Smokers should be offered advice to stop smoking by health professionals who are in regular contact with them, with the offer of support to be delivered by the specialist service staff, working closely with mental health staff. NRT (or in special circumstances bupropion when it is not contraindicated) should be considered for psychiatric patients because of their high levels of dependence.

Those offering specialist support to smokers with mental health problems will need to consider any potential drug interactions, both with smoking and with cessation support. Cigarette smokers are generally prescribed higher neuroleptic medication (56). This may be due to a faster metabolism of antipsychotic drugs, which means that stopping cigarette smoking may result in an increase in antipsychotic drug levels in the blood. This may require a reduction in the amount of antipsychotic drug they should be prescribed. In addition, the choice of neuroleptic medication influences smoking behaviour. For example, clozapine is associated with a decrease in smoking and haloperidol is associated with an increase in smoking and nicotine blood levels (57, 58).

Smoking cessation specialists have the opportunity to provide support to smokers who have enduring mental health problems and who live either within institutional settings or the community. When providing smoking cessation support, specialists should take into consideration the possible need for individual support rather than group support. Mental health care professionals working closely with the smoking cessation specialists should monitor the patients carefully after the quit attempt, to assess and support any changes in mental health state.

Smokers with cardiovascular disease (CVD)

Evidence

The risks of continued smoking in those with pre-existing CVD are very high. Stopping smoking should be an urgent priority as this will slow the progression of the disease and reduce the risk of it recurring. For example, smoking cessation can reduce the risk of recurrence or premature death by about 50% in smokers with coronary heart disease (CHD) (59). Several guidelines published by the Scottish Intercollegiate Guidelines Network (SIGN) refer to the importance of smoking cessation in patients with CVD and stroke (see www.sign.ac.uk) (7).

Although the long-term efficacy of NRT in patients with CHD is unproven, NRT is a safer means of nicotine delivery than cigarettes because it provides less nicotine at a slower rate and without other smoke constituents such as carbon monoxide, known to have a deleterious effect on the cardiovascular system. In one study, bupropion has been found to improve the chances of success of cardiac patients wanting to stop (8). It has been found to be safe in this group of patients (8).

Best practice

Health professionals can be reluctant to prescribe NRT to patients with CVD because most of the NRT products include some sort of cautionary statement about their use with this group of patients. However, recent guidelines recommended that NRT should be made available to smokers with CHD who are motivated to stop (60). These guidelines recommend that NRT may be appropriate for many patients who have experienced a serious cardiovascular event within the past four weeks, although the patient's consulting physician should be involved in the decision to use NRT. Physician involvement was not needed in less acute cases.

NICE recommends that patients with unstable CVD should discuss the use of NRT with a relevant health professional before it is prescribed. This recommendation has been endorsed as valid for Scotland by the Health Technology Board for Scotland (now part of NHS Quality Improvement Scotland).

At present there are no studies that can guide the tailoring of behavioural support to cardiac patients and it therefore seems reasonable for them to engage with the normal SCSs. Close links will be needed between the SCSs, hospital specialists and cardiac rehabilitation centres. There is often a gap between discharge and starting the cardiac rehabilitation programme, and this tends to be when most people relapse. Hence it would be helpful if staff who provide care at home could undertake basic cessation training/awareness raising so that they know how to support and refer people to specialist help during this time.

Smokers with chest conditions

Evidence

The Scottish cancer strategy emphasises the importance of smoking cessation in patients with lung cancer (NHS HDL (2001) 54). A recent review has concluded that stopping smoking may be more important in relation to survival than receiving medication for the cancer (61).

There is one very large trial showing that patients with mild to moderate chronic obstructive pulmonary disease (COPD) can benefit from behavioural support plus NRT (62). Other research indicates that bupropion can help smokers with COPD to stop (63). However, there are no published controlled trials on smokers with moderate to severe COPD, asthma or lung cancer.

Best practice

It seems reasonable to try to persuade patients with impaired lung function to stop as early as possible. However, if their condition gets to the stage where they are attending a chest clinic, routine, tailored advice plus a recommendation to use the SCSs seems most appropriate, pending further research.

Diabetic smokers

Evidence

The risks to health of smoking among diabetic patients are particularly high and it is imperative that they be strongly advised to stop and given as much support as possible to enable them to achieve this goal. The importance of smoking cessation is emphasised in the SIGN guidelines on diabetes (64). No studies have looked at smoking cessation treatment methods in this group, so any recommendations must be based on more general principles. There is, however, an increased risk of seizure when bupropion is prescribed to patients who are already at risk from hypoglycaemia.

Best practice

It is appropriate for clinicians treating diabetic smokers to provide clear and personalised information on the risks and to have close links with the SCSs to enable efficient referral to these.

The labelling for NRT states that diabetic patients should use these products with caution. However, common sense should indicate that providing nicotine to smokers already getting nicotine from cigarettes would, if anything, encourage smoking cessation rather than pose any risk.

Older smokers

Evidence

Stopping smoking is important for older smokers who may already be experiencing smoking-related diseases. Giving up smoking, even after the age of 60, will reduce the risk of smoking-related diseases and decrease the time needed to recover from many illnesses (59).

Best practice

There is no evidence to suggest a different approach with older smokers. However, it is likely that older smokers will have been smoking for many years, perhaps decades, and they may have tried to quit several times in the past and failed. Referral to SCSs would therefore be even more important for an older smoker, to give them the best chances of success.

Recommendation 4

Where practicable, SCSs should offer outreach to non-NHS locations such as workplaces and prisons.

4.1 Where resources allow, SCSs should liaise with major employers, such as NHS Scotland and Scottish local authorities, and other local employers to determine whether there is a demand for cessation treatment services based in the workplace, and where practicable should offer that provision.

4.2 Where resources allow, SCSs should liaise with local institutions such as prisons to determine whether there is a demand for cessation treatment services based in those institutions, and where practicable should offer that provision.

4.3 The Scottish Prison Service (SPS) should ensure that NRT is available to prisoners across the service who wish to stop smoking.

Evidence

The workplace setting has recently been identified by the Scottish Executive as providing a major opportunity for health improvement. If programmes encourage quit attempts in smokers who would not have tried to quit and lead smokers to use behavioural support and/or medication who would otherwise not have done, then they serve a valuable function.

Smoking prevalence in prisons and other institutions with residential occupation is very high. At present there is no evidence from controlled trials regarding the effectiveness of behavioural support programmes in such places, but pilot work is under way to assess its feasibility. It seems reasonable to assess demand for such services in these institutions and, subject to other priorities, to set up services commensurate with that demand.

Best practice

Scotland's Health At Work (SHAW) is a national award scheme (Bronze, Silver and Gold Awards) for employers who demonstrate commitment to improving the health and ultimately the performance of their workforce. The scheme is supported by a range of organisations including the Scottish Executive, Health Scotland, the Scottish NHS Boards and the Confederation of Scottish Local Authorities (COSLA). A core criterion of achieving the Bronze Award, for example, is that the workplace needs to *'Implement a stated policy on smoking that promotes a smoke-free environment and provides smoking cessation support'*.

Ideally, all medium- and large-sized workplaces should have smoking policies that protect the health and welfare of non-smokers and encourage and support smoking cessation. Health Scotland, ASH Scotland and COSLA have recently published guidelines for local authorities concerning tobacco at work (65).

A range of other resources is available to guide the setting up of workplace smoking policies and these include advice on supporting cessation attempts. Now that there are NHS Scotland SCSs, it seems advisable for the support for smoking cessation to be co-ordinated with these services. Workplace schemes such as SHAW and workplace health promotion and occupational health all provide referral opportunities to SCSs.

As regards prison populations, the Department of Health in England has recently produced some guidance concerning smoking cessation in prisons (66). In Scotland, NRT cannot be prescribed under the NHS in prisons and funding for NRT therefore needs to be included within prison budgets. The SPS should establish a prescribing policy across the service. Prison establishments can provide smoking cessation clinics for prisoners, and if required prescribe NRT or bupropion as part of such clinics. The SPS does not make additional resources available for this, so individual prisons have to find their own resources, which they have achieved to varying extents. Prison services could set up contracts with cessation services to provide support.

The SPS is also considering developing a policy for smoke-free areas in all establishments. Some already have designated areas, but in others there has been opposition from prisoners and staff. A central policy will probably help this situation.

NHS BORDERS

Smoking Awareness Service SHAW (Scotland's Health at Work)

This case study is an example of a SCS based in the workplace.

Catchment
Rural, mixed

Location
Workplace

Service Description
This service is a SCS group based within a Borders factory that employs about 400 workers. Following individual assessment for motivation to quit and suitability for NRT, support is offered through a group, held in the workplace, that runs for eight weeks. The Smoking Awareness Service provides a group facilitator who attends the workplace weekly to run the group, organise prescriptions for NRT, liaise with GPs in the town, liaise with the employers and organise three monthly follow-up sessions.

The need for this service in the workplace was identified when the business decided to sign up to SHAW (Scotland's Health at Work) and work to achieve their Bronze Award (the awards reward employers who demonstrate commitment to improving the health and ultimately the performance of their workforce). Part of the Bronze Award is the development of a workplace smoking/tobacco policy, and support for those who wish to quit.

There is partnership working between SHAW, Smoking Awareness Service, general practices in the four Borders towns, employers and employees.

Training for an employee in smoking cessation support was identified as a need by the participants, and is planned as part of a SHAW training programme. This will ensure that the service becomes sustainable and will build the health promoting capacity of the workplace.

Recommendation 5

NHS Boards should ensure that a board-wide SCS (or services) of sufficient scale and organisation to meet the needs of the population and the geography of the area is available. Services should be provided with stable funding as a core part of NHS Scotland provision, under the direction of full-time-equivalent NHS Board smoking cessation co-ordinators.

5.1 Each NHS Board should fund one or more SCS depending on the size and geographic distribution of its population of smokers.

5.2 The SCSs should be open to all smokers motivated to quit irrespective of their age, gender, ethnicity or social class, and whether or not they are suffering from smoking-related conditions.

5.3 Funding of the services should be on a permanent rather than a temporary basis.

5.4 Funding should be ring-fenced, at least until the services have become fully embedded.

5.5 Each mainland NHS Board should have at least one full-time-equivalent (FTE) NHS Board smoking cessation co-ordinator and the Islands at least 0.5 FTE NHS Board smoking cessation co-ordinator. These co-ordinators have overall responsibility for the management, running and evaluation of all aspects of the service.

5.6 Each SCS should employ a minimum core staff of two FTEs depending on the population spread and size, in addition to the co-ordinator. These staff should provide treatment to smokers and/or support a larger group of community smoking cessation specialists operating in primary care. The aim is to ensure that the service can be provided locally and has the flexibility to adapt to variations in demand and avoid smokers having to wait for treatment.

5.7 SCSs should be staffed by specially trained individuals with dedicated time set aside for the purpose rather than attempting to combine the job with other duties.

5.8 Each SCS will also need to employ appropriate administrative/clerical support.

5.9 NHS Board smoking cessation co-ordinators need to act as a key point of contact with other professionals and organisations: one way of doing this is to set up an advisory/co-ordinating committee. Health professionals need up-to-date information on the smoking cessation services in their area, so NHS Board smoking cessation co-ordinators should ensure that they have a system for updating local health professionals about the services available.

Rationale and best practice

All smokers should have access to SCSs offering behavioural and pharmacological support provided by specially trained personnel. Evidence from the smoking cessation services set up in England in 1999 indicates that they have achieved four-week validated (by expired-air carbon monoxide measurements) quit rates of 39% (67).

NHS Boards should provide a board-wide SCS (or services) of sufficient scale and organisation to meet the needs of the population and the geography of the area. One or more SCS will need to be funded in their area depending on the size of their local population and demand. One service should be able to serve an adult population of about 250,000. Experience has shown that it is neither effective nor sustainable to organise SCSs at an individual practice level without adequate core support and outside a larger structure (68-70).

In order to maximise public health gain from the SCSs, they should be open to all smokers motivated to quit. The focus on the White Paper priority groups is important but, given the health consequences of smoking for all smokers, it is important that any smoker wanting to stop should be able to receive support with stopping from NHS Scotland.

NHS LANARKSHIRE

Smoking Cessation Service

This case study illustrates how an NHS Board has developed a smoking cessation strategy for the region. The following information has been extracted from the document entitled *Lanarkshire Smoking Cessation Strategy* (NHS Lanarkshire, 12 March 2003).

Service Description
The aim of the *Lanarkshire Smoking Cessation Strategy* is to minimise tobacco use by providing a range of effective SCSs at community, workplace, primary care and hospital levels. In order to achieve an increase in the level of long-term smoking cessation by 1% annually, the following service configuration was recommended:

1. Brief advice from GPs and other health professionals.
2. Specialist LHCC-based community cessation services for smokers requiring more than brief advice.
3. Specialist cessation support should be given to hospital patients, smokers with mental health problems, pregnant smokers and smokers in prison.
4. A pan-Lanarkshire smoking cessation co-ordinator should be identified to manage the implementation of consistent, equitable services throughout Lanarkshire. Co-ordinated marketing with an area-wide advertising campaign including publicity, leaflets and stable contact points is integral to the service development.
5. A standard database from which data can be combined for analysis across Lanarkshire without double counting should be used by all cessation services.

Noting that careful audit would be necessary to ensure that recruitment and cessation rates are maintained over time, the strategy supported eight SCSs, each with its own co-ordinator, one in each of the LHCCs in Lanarkshire. Current smoking cessation activities in Lanarkshire are funded largely through the HCH Allocation, then the HIF and by LHCCs. LHCC-based specialist services also provide NRT to many patients under local PGDs.

Permanent funding of the services is required, as short-term funding leads to job insecurity, resulting in a high staff turnover and difficulties with recruiting staff. Running specialist services requires skills and experience and a high staff turnover does not allow appropriate expertise to be developed and sustained. A high staff turnover is also a waste of valuable resources. A survey of smoking cessation co-ordinators in England in 2001 indicated that many were experiencing difficulties in recruiting and retaining staff, one of the most common reasons being short-term funding (71). The evaluation of the English services has also shown that services experiencing staffing problems had fewer self-reported quitters at four weeks than other services (25).

Dedicated staff are needed to manage the services. Each SCS should be led by a FTE smoking cessation co-ordinator who has overall responsibility for the service including: commissioning and organising training, ensuring the service adapts to changing needs, ensuring that there are protocols for NRT and bupropion availability and supply; ensuring the service is adequately publicised; and acting as the link with other services, NHS Scotland bodies and wider tobacco control activities. Co-ordinators should be encouraged to maintain their clinical skills and not to take on a purely management role so that they remain able to offer authoritative advice and support to the team. The experience of the English SCSs has indicated that lower rates of four-week self-reported cessation rates and higher rates of loss to follow up were observed if the smoking cessation co-ordinator had responsibilities other than running the services (25).
In addition to the co-ordinator, each specialist service needs additional staff to treat smokers.

NHS GRAMPIAN

Smoking Advice Service

This case study is an example of good practice. The SCS is well funded, staffed, and offers a comprehensive treatment strategy to smokers through a number of different settings and approaches. Monitoring data are also routinely collected and evaluation reports are available.

Catchment
Mixed — urban/rural and deprived/affluent

Location
Primary and secondary care, community setting

Service Description
The service consists of a core team comprising a smoking cessation co-ordinator, assistant co-ordinator and five part-time (22.5 hrs per week) cessation advisers. HIF supports two secondary care posts totalling 25 hours and covering four different sites. The core team has responsibility for training (for all levels of interventions and a variety of primary and secondary care professionals), providing support for the settings-based advisers and resources for both professionals and the general public. The assistant co-ordinator's main task is to oversee the service evaluation.

The service is pan-Grampian and accessible to all, with an emphasis on pregnant smokers and their partners and low-income smokers. It is overseen by a sub-group comprising representation from a wide range of disciplines and organisations. The service provides intensive support for clients via a six-week programme. Primary care based professionals tend to provide brief intervention support to patients and refer to the service for more intensive support. Trained pharmacists can use a PGD which enables them to supply NRT to the 'high risk user groups' such as pregnant women, young people and those with medical conditions who might otherwise be excluded from using treatments. Two evaluation reports are available.

Data from January–December 2001

Referrals[1]	5006
Registrations[2]	3398 (68%)
Attended 1 or more sessions	2673 (79% of 3398)
Attended complete course	815 (24% of 3398)
Point cessation at end of course[3]	30%
Point cessation at 3 months[3]	19%
Continuous cessation at 3 months[3]	16%
Point cessation at 12 months[3]	13%
Continuous cessation at 12 months[3]	12%

1 77% GP referrals, 19% self-referrals, remainder referred from other health professional
2 These figures are approximately double the 2000 figures
3 Assuming those with incomplete follow-up data were continuing smokers

The number of staff needed will depend on the size and spread of the catchment area. It is estimated that **at least** two FTEs in addition to the co-ordinator are required for an adult population of around 250,000.

Flexibility is also needed in delivery of the services. In Scotland there is already a range of models of service delivery due to very high smoking prevalence, as well as population sparcity and transport issues in some of the NHS Boards.

Some parts of Scotland outside the central belt are very sparsely populated which means that more smokers may need to be treated individually rather than in groups. For group treatment to be sustainable, a throughput of at least 20 smokers per group is needed, which translates to a local population of approximately 250,000 smokers for a sustainable programme. Whilst individual treatment needs skills and experience and the support of core staff, it can be undertaken on a sessional basis by trained health professionals in the community, such as practice nurses and pharmacists. This approach is essential to enable the services to respond to changes in demand (e.g. at New Year, following the budget or in response to promotional campaigns) without making smokers wait for treatment.

It is important that the different models of service delivery are fully evaluated.

NHS GREATER GLASGOW

Starting Fresh with the Glasgow Pharmacy Stop Smoking Project

This case study is an example of a service working with community pharmacies.

Catchment
Urban. The service currently operates in over 50% of community pharmacies (n=113) in the Greater Glasgow area. The majority are in areas of high social deprivation where smoking prevalence can be up to twice the national average.

Setting
Primary care, community settings

Service Description
This primary care project was piloted in 2002/03 and initiated in June 2003 as a recognised service across Glasgow. There are three strands to the project that are described below. In addition, each participating pharmacy must provide:

- provide a confidential advice area
- have pharmacists and assistants who have undergone smoking cessation training that is recognised by NHS Greater Glasgow
- supply project literature for all potential clients
- comply with standard operational procedures.

a) Pharmacy prescribing of NRT
Patients motivated to quit smoking can attend the community pharmacy where they will be prescribed weekly supplies of NRT (for a maximum of 12 weeks). In addition, 5-10 minutes of support will be given and CO levels measured at each visit.

b) Pharmacy support for GP/nurse prescribing of NRT
Here the NRT is dispensed on a weekly basis with appropriate support and counselling as detailed above.

c) LHCC intensive group support
The groups run for seven weeks. The first week involves assessment of motivation to quit and level of addiction, together with the setting of a quit date, advice on appropriate NRT product and details on local pharmacy for the direct supply of NRT. A quit date is set for week three. The remaining weeks focus on behavioural change, support, motivation and problem solving. Each week the patient collects their NRT from their local community pharmacy. When the group has finished, the patient returns to the pharmacy to receive NRT which is supplied on a weekly basis for a further five weeks, together with relevant support.

In all three strands, patients are followed up at six months by telephone interview to assess their smoking status. At 12 months after their quit date, they are again contacted by telephone and if still a non-smoker, they are invited to have their CO levels measured at the pharmacy to validate their status.

Advertising materials have been developed and are widely available in community pharmacies, GP and dental surgeries and even Glasgow taxis. A free helpline number has also been set up and operates 12 hours a day, seven days per week.

The target is to extend this network to all pharmacies in Glasgow.

NHS ORKNEY

The Stop Smoking Service

This case study illustrates a service operating in a remote and rural islands archipelago. The model of service provision makes good use of very limited resources rather than being an ideal model. The co-ordinator would like to have sufficient funding to take the service out to rural GP practices to engage with clients face to face, and also provide updates and support on smoking cessation to primary care teams. Some primary care professionals outside Kirkwall do not refer clients, despite the promotion of the service, because many clients would prefer to deal with someone face to face in their area.

Catchment
Remote, rural islands archipelago

Location
Community

Service Description
The Stop Smoking Service, based within the Health Promotion Service with its drop-in Health Information Centre, is limited by funding to seven hours per week (0.2WTE) of smoking cessation specialist time. It is based in Kirkwall, the largest town on the largest island of this group of 20 inhabited islands. The smoking specialist can offer either daytime or evening slots to meet the needs of clients, even within this very limited service. The difficulties of a fixed base and scattered client group are overcome by the specialist developing relationships with primary care teams based outside Kirkwall through telephone contact, and by promoting a telephone-based counselling service.

The Health Information Centre provides pre-appointment packs with information and tools that enable the client to think about their individual habit prior to discussion with the cessation specialist. The cessation specialist may contact the client's GP to recommend prescribing of NRT or bupropion.

Isle GPs refer patients to the service, which has an overall success rate of more than 50% not smoking at three-month follow up. Clients who have accessed the service by telephone do not have significantly different quit rates from those who access it face to face.

The Scottish Executive is introducing interim annual cessation targets for each NHS Board in 2004. We currently suggest a minimum of two staff in addition to the co-ordinator for each SCS in Scotland, but this should be reviewed when the targets are introduced and in the light of the substantial uplift in funding for SCSs announced with the Tobacco Control Action Plan for the year 2005/06 (72).

It is important that the SCS staff (both core and sessional) are trained, use their skills on a regular basis and keep up-to-date with smoking cessation research. Research has shown that this support cannot be given by health professionals attempting to give smoking cessation support alongside other duties.

Where there is more than one SCS in an NHS Board area, one co-ordinator (or another member of staff within the NHS Board) should oversee the delivery of the services across the NHS Board area and act as a link with other staff and activities at the NHS Board level.

Given the need for smoking cessation interventions to be co-ordinated over a number of professional groups, the NHS Board smoking cessation co-ordinator should act as the link between other professionals within the LHCC (future Community Health Partnerships [CHPs]) and the NHS Board. One way of doing this is to establish an advisory or co-ordinating committee with members from a wide range of professional backgrounds.

Recommendation 6

Organisations and agencies in the health service should all have clearly defined roles in relation to the funding, promotion and provision of SCSs, with overall co-ordination at an NHS Board level.

6.1 NHS Boards should provide a board-wide SCS (or services), providing evidence-based support for smokers who wish to give up, in order to produce cost-effective and significant health improvement in the population.

6.2 In areas of high population density, where more than one SCS is needed per NHS Board, LHCCs (and future CHPs) can provide the SCS within an overall board-wide SCS strategy. Alternatively, where the LHCC (or future CHP) does not cover a large enough population, it can combine resources with other LHCCs such that one LHCC manages the SCS for the whole area, if the spread of the local population is not too wide. Combining resources in this way has the advantage of enabling group treatment to be offered; it might not have been viable in a smaller area. The LHCC/CHP level services need to be co-ordinated at NHS Board level.

6.3 The Scottish Executive should be the body responsible for establishing a national monitoring scheme for the services based on work conducted by PATH.

6.4 The Scottish Executive should also be responsible for establishing quality standards for training for those providing brief interventions and/or specialist support based on work conducted by PATH.

6.5 NHS Boards should take on responsibility for ensuring that all health care facilities including hospital and community psychiatric institutions in their local areas are smoke-free.

Rationale and best practice

It would be easy in a complex healthcare environment for there to be duplication of effort or for services to be set up in an unco-ordinated way, leading to wasted resources. NHS Boards receive funding from the Scottish Executive and are best placed to determine funding priorities at local level. The NHS Board should provide a board-wide SCS (or services, depending on the size of the NHS Board population). If there is more than one service, the services could be organised at an LHCC level or by group of LHCCs.

It is important that the effectiveness of SCSs is monitored so that they can develop according to best practice. PATH has been tasked with making recommendations about establishing a system for monitoring and evaluating the SCSs. Building on this, the Scottish Executive should set up a minimum data set that all services should routinely collect (see page 46). The services should work with health professionals to put systems in place to maintain an up-to-date record of smoking status of all their patients, record advice and support received and ensure appropriate referral mechanisms to the SCS are set up.

Reliable data on smoking in pregnancy is needed at a local level to help delivery and monitoring of interventions. Smoking status is routinely recorded at first clinic booking and at delivery through SMRO2, although interpretation of smoking at delivery varies. More detailed data should be collected in addition to this such as the advice given, any action taken, and smoking in the 12 months leading up to pregnancy. This additional information should be recorded through the Scottish Women's Maternity Record (SWMR) which is currently being developed by Quality Improvement Scotland.

PATH has also been tasked to develop quality standards for the content and delivery of training for both brief advice to stop smoking and specialist smoking cessation support (see page 43). This work links with the development of training standards by the Health Development Agency in England and the Department of Health, Social Services and Public Safety in Northern Ireland. The agreed quality standards should be adopted by the Scottish Executive.

NHS Boards are best placed to ensure that all health care facilities in their areas including hospital and community psychiatric institutions have adequately implemented smoking policies.

Where NHS Boards cover a large population, more than one specialist service should be developed. LHCCs (and future CHPs) can integrate services so that they cover a sufficiently large population in order to be able to provide group treatment programmes, if the spread of the local population is not too great.

Recommendation 7

Relevant NHS staff and health and related professionals in local authorities and the voluntary sector should be provided with training that is in line with the *Standards for Smoking Cessation Training in Scotland* and appropriate to their role in cessation, whether it be the provision of brief advice or specialist cessation support.

7.1 All relevant health and related professionals should be trained to enable them to deliver brief advice to stop smoking.

7.2 All those providing specialist cessation support should receive appropriate training and receive training updates every year.

7.3 Courses on the provision of brief advice and specialist cessation support for individuals or groups should meet National Training Standards.

7.4 Scottish schools of medicine, nursing and midwifery, pharmacy and dentistry should ensure that tobacco education and smoking cessation form part of the core curriculum of basic training for all health professionals. Updating knowledge and skills in this area should form part of their continuing professional development (CPD).

7.5 The recommendations outlined in the national *Strategy for Smoking Cessation Training in Scotland* should be taken forward.

Rationale and best practice

Training increases the likelihood that health and health-related professionals will carry out smoking cessation interventions. As interventions for smoking cessation have been shown to be effective, training seems very likely to improve outcomes, although this has not been directly demonstrated through research (73).

PATH has developed a *Strategy for Smoking Cessation Training in Scotland* in consultation with various relevant stakeholders. The recommendations outlined here reflect the main elements of this strategy. (See www.ashscotland.org.uk/path/strategy.doc)

PATH has also developed national standards for training in brief advice and specialist support for smoking cessation. These are based on research evidence and the results of training needs assessment with those who work in smoking cessation. The standards aim to increase both quality and consistency in the provision of smoking cessation training.
(See www.ashscotland.org.uk/path/standards.pdf)

PATH is to set up an approval scheme whereby course content and learning outcomes are assessed against the national training standards. Courses approved by PATH may then be promoted by training providers as being in line with national standards. PATH will also investigate the various options for formal accreditation.

NHS TAYSIDE (1)

Smoking Cessation (Angus LHCC)

This case study illustrates how trained sessional staff can give flexibility to the provision of smoking cessation support. The sessional staff complement the specialist smoking cessation support staff in times of high demand.

Catchment
Mixed — urban/rural and deprived/affluent

Location
Primary Care — delivered mainly in health/medical centres

Service Description
Throughout the Angus area people who wish to stop smoking are referred to the nearest quit smoking group or one-to-one provision. Where NRT support has been requested it is normally made a condition that the patient/client attends group support sessions.

Often it is difficult to match exactly demand for support with provision, therefore in the early days of White Paper funding it was decided to train and retain a group of sessional staff who could supplement the existing practice staff. The sessional staff were trained to exactly the same level as the existing staff members such as the health visitors and practice nurses (i.e. completion of the one-day Smoking Cessation Tutor Training course).

The sessional workers have, and currently still do, run groups in their own right; they also complement the practice teams in times of high demand. They are a very flexible resource that can be directed to the quit smoking 'hotspots' as and when they arise.

NHS TAYSIDE (2)

Special Study Module for Medical Students
Smoking — the role of health promotion
Ninewells Hospital Medical School, Tayside

This case study describes a smoking module for medical students which has been running since at least 1997. It is currently only optional.

Course Description
Each year between 10 and 20 second- and third-year medical students opt for a study module on smoking at Ninewells Hospital Medical School, Dundee. The programme content consists of three main elements:

- specialist lecture/seminar-type input from several of the senior health promotion officers on subjects such as smoking in the workplace, the psychology of smoking behaviour, etc.
- participation in a debate on a number of tobacco-related topics
- a presentation on a tobacco-related topic of the students' own choosing with the option of a collaborative effort in pairs or threes.

Throughout, the students are encouraged to read around the subject and use resources such as the Internet to supplement the lecture content. Many students research in considerable detail.

The students are assessed on the basis of the debate, the presentation and their overall attendance and participation. The students also give feedback on their perception of the module and regularly express 'enjoyment' of the format and comment on the 'usefulness' of the content.

The field of smoking cessation is rapidly changing; new research and evidence is emerging regularly. Those providing specialist support for smoking cessation training should, where possible, receive update training every year. To allow individuals to attend all levels of initial and update smoking cessation training, protected time for training and funding for locum replacements will be required. This measure is likely to facilitate and increase the uptake of training.

Recommendation 8

NHS smoking cessation activities should be monitored using a minimum set of indices, and figures reported annually to key stakeholders.

8.1 General practices should monitor the percentage of adults (aged 15 and over[6]) who smoke and who have been advised to stop.

8.2 SCSs should collect a core set of data on each client, to provide monitoring information on a) the number of clients who set a quit date, b) key demographic characteristics of these clients (e.g. age, sex, ethnicity, socio-economic status, and if pregnant), and c) information on these clients' smoking behaviours and their quit attempts (e.g. number of cigarettes smoked, number of previous quit attempts, type of intervention received, receipt of NRT and/or bupropion).

8.3 SCSs should also provide monitoring information on the number of clients who a) have been contacted to determine their smoking status one month after the quit date, b) report at this stage that they have not smoked at all for at least two weeks, and c) are confirmed as not smoking at that time by means of a carbon monoxide breath test.

8.4 Attempts should be made to follow up at 3 and 12 months all smokers reporting abstinence at the one-month point (see above). Services should report the numbers who a) have been successfully contacted at 3 and 12 months, b) report that they have smoked fewer than five cigarettes since the one-month point, and c) report that they have not smoked at all for at least two weeks.

Rationale and best practice

A key goal at the population level is to reduce smoking prevalence. Health boards are required to record relevant information on their SCSs and to assess their performance against targets set out in the White Paper *Towards a Healthier Scotland* and the amended target set for adults (aged 16-64) of 29% by 2010 in the new Tobacco Control Action Plan *A Breath of Fresh Air for Scotland*. The Action Plan also gave an undertaking to revisit the other targets in light of further data which will become available in 2005 and health boards will need to take account of the outcome of this review when it is available in 2005. Routine monitoring at both general practice level and within specialist SCSs is achievable, and provides crucial management information on how far goals are being achieved at the local level.

A mapping exercise completed by Partnership Action on Tobacco and Health (PATH) in 2003 revealed that there was immense diversity in the monitoring and evaluation practices of Scottish SCSs (74). It is difficult to interpret and compare outcomes nationally when services collect different data and use different criteria to define a successful quit. In the English SCSs it has been found that one critical variation is whether carbon monoxide verification was required: four-week quit rates based on self-report are some 18 percentage points higher than those with carbon monoxide verification (53% by self report versus 35% CO verified) (75).

To introduce consistency across Scotland and enhance the validity of monitoring and evaluation information, services should be monitored using standard definitions of key terms and standardised procedures. PATH was tasked with creating a national minimum dataset and a best practice data collection protocol for this purpose. These were developed in consultation with smoking cessation experts, and are currently being piloted. When implemented they will facilitate comparisons of service outcomes, both within Scotland and with the rest of the UK. To contribute to the maintenance and development of standards, services should develop routine mechanisms for reporting to local stakeholders and policy-makers.

6 As required by the new GMS contract 14. Department of Health (2003). *Investing in General Practice. The New General Medical Services Contract*

The most efficient and effective method of organising monitoring would be for a single agency to enter data and provide the quantitative reports. This could be done by completing a common Scotland-wide, web-based, password-protected form. It would be relatively straightforward for the agency to ensure that data and quantitative reports for each service were available on a continuous basis electronically via the web.

In addition to the key monitoring data contained in the national minimum dataset, services should continue to collect further information that they find useful for their own purposes. This may include core client data such as contact details and medical information, further details about clients' tobacco use and motivation to stop, and additional information on the outcomes of an intervention (e.g. changes in tobacco use and attitudes to smoking).

Clients should also be given the opportunity to evaluate the service. Data on other aspects of service provision (e.g. staffing levels, funding and costs, waiting lists, number of enquiries, drop-out rates) may also be collected. All the above information will provide a more general context to service provision, achievements and challenges which is useful for evaluating the strengths and weaknesses of the service, and for guiding future service developments.

Recommendation 9

Other smoking cessation interventions, such as No Smoking Day and Smokeline, should be used where appropriate to support the SCSs.

9.1 No Smoking Day should continue to be funded, triggering as many quit attempts as possible. Promotion around the Day should direct smokers to NHS SCSs.

9.2 The Scottish national freephone, Smokeline and e-Smokeline should revise its protocols and procedures in the light of these guidelines. It should maintain up-to-date contact details of all the SCSs and routinely encourage callers to use their local service.

Rationale and best practice

No Smoking Day can be an important trigger for quit attempts. Of course it is not feasible to undertake controlled trials to estimate the proportion of quit attempts that would have occurred in the course of a year anyway but it is a reasonable presumption that No Smoking Day substantially increases quit attempts around the day itself and also contributes to raising the profile of cessation, which can enhance quit rates throughout the year. In recent years an important emphasis of No Smoking Day has been on encouraging smokers to use effective treatments in their quit attempts. It is reasonable to assume that No Smoking Day can be a source of clients for the SCSs. However, this requires clear and concrete advice to smokers, and the provision of information which is likely to make the service attractive to them.

No Smoking Day materials and publicity should provide clear, consistent and concrete advice and information regarding smokers' local SCSs. Since most smokers will have little idea what the treatment service involves, or the extent to which it can improve the chances of success and ultimately prevent illness and death, it would seem reasonable to use the opportunity to provide that information.

A follow-up of the Scottish freephone Smokeline has suggested that large numbers of smokers use this service. Quit rates following use of the service appear to be high (75). The figures have fallen recently but this remains an important source of clients for the SCSs. Protocols and procedures used by Smokeline (and the electronic version, e-Smokeline) will need to be revised in the light of these guidelines. As with No Smoking Day, it is important that Smokeline and e-Smokeline convey information to smokers on the benefits of seeking treatment from the SCSs. NHS24 should also refer smokers to SCSs.

Recommendation 10

Research is needed as a matter of priority into a) methods of encouraging more smokers to use the effective treatments that are available, b) the delivery of effective treatments to special groups such as pregnant women and psychiatric patients, c) what constitutes structure and best practice in the delivery of support by the SCSs, and d) the implications of cannabis use for smoking cessation.

Rationale

It is apparent from the previous recommendations that there are large gaps in our knowledge about how best to help smokers to overcome their dependence on cigarettes. Among the many possible issues that might be part of a Scottish Tobacco Control Research Strategy, the following should have a high priority:

How to encourage more smokers to use effective treatments. In England it is estimated that about 4% of smokers are using SCSs each year with about 50% using NRT. Equivalent data are not currently available for Scotland but service uptake is not likely to be as high as this. It should be possible to increase both the proportion of smokers attending Scottish SCSs and the proportion using NRT but little is known about smokers' motivations or barriers to seeking help. These might include: lack of knowledge about treatment effectiveness; lack of urgency in motivation to stop; concerns over side effects; embarrassment and unwillingness to seek help.

How best to treat smokers in special groups. Controlled trials are urgently needed with special populations for whom at present no firm recommendations can be made. These include pregnant smokers, psychiatric patients, young smokers and smokers in prisons.

What constitutes structure and best practice in the delivery of smoking cessation treatment. Different services operate different systems with: greater or lesser provision of group treatment; different durations or frequency of contact; greater or lesser use of core staff to provide treatment; more or less specific treatment protocols etc. At present, we do not know how much difference this makes to key performance indicators such as reach and success rates. Implementation of data collection across all SCSs using the PATH minimum dataset will permit the collection of outcome data in a rigorous and systematic way. However, additional research will also be required to fully determine the attributes of the most successful approaches to service delivery.

Many cigarette smokers (particularly young smokers) also use cannabis and there is no clear advice on **how to treat smokers wishing to stop smoking tobacco but who may wish to continue their cannabis use**. The implications of cannabis use for smoking cessation should be further explored.

Appendix 1:

Pilot Smoking Cessation Services Aimed at Young Smokers

Project	Target Group	Setting	Main Approaches
1	Vulnerable young people, 12-18 years	Youth and community	Alternatives to smoking; relapse prevention
2	Pregnant women under 25 years and partners	Primary care; hospital; community	Smoking cessation clinic; professional training
3	Socially excluded young people, 11-15 years	Informal youth; community	Smoking cessation support
4	Young people in island communities	Further education; informal youth	Smoking cessation support
5	Rural youth, 13-17 years	School; community	Web-based chat room
6	Young people in diverse geographical areas, 15-24 years	Community; informal youth	Mobile bus; peer workers
7	Further education students	Further education college	Smoking cessation groups; individual counselling
8	Young offenders, 12-21 years	Young offenders' institute	Creating a supportive, smoke-free environment

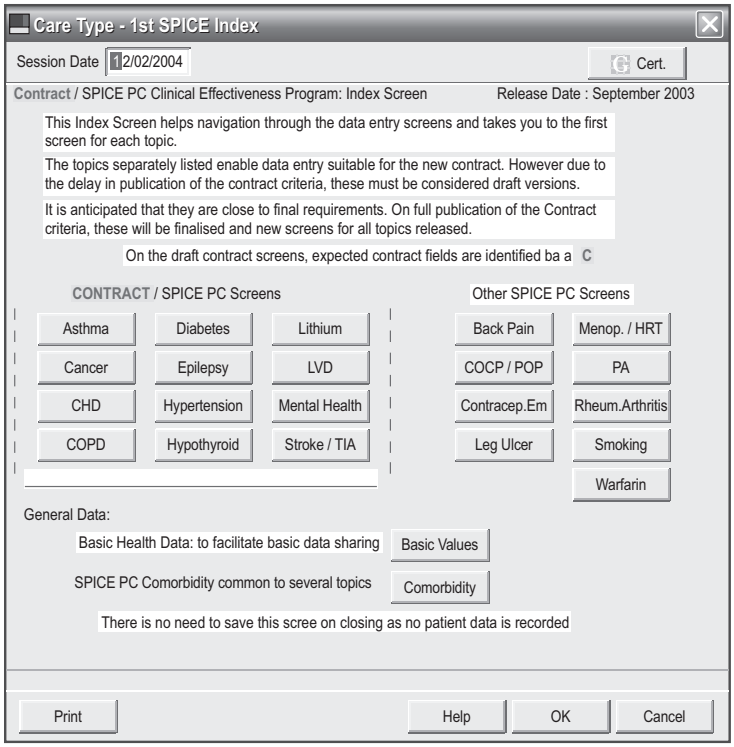
Appendix 2:

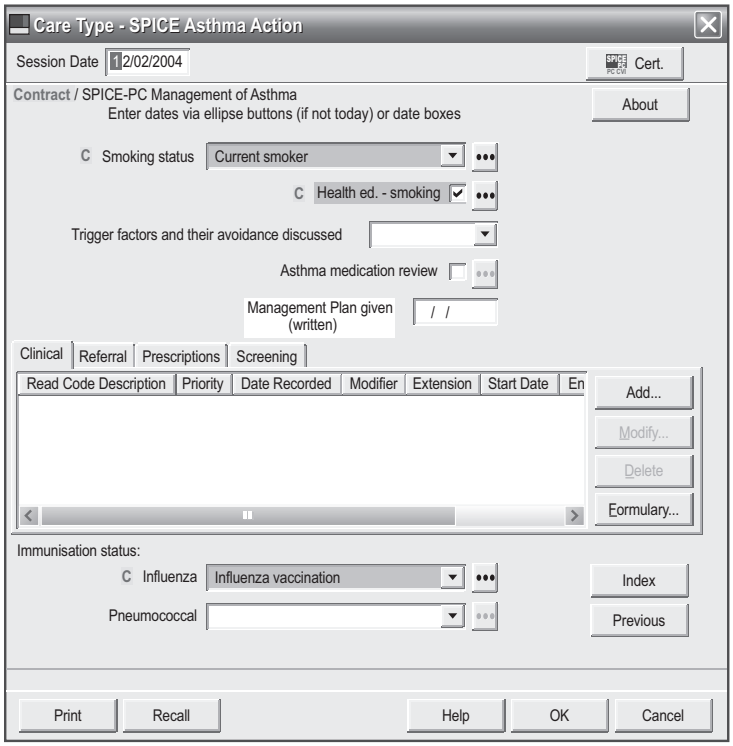
GPASS (see Recommendations 2.3 and 2.4)

GPASS is the most commonly used patient record system in general practice. An estimated 85% of practices in Scotland use the system. The screens are updated regularly in response to recommendations from users.

At present, smoking status and the provision of smoking cessation should be recorded via the chronic disease screens (contract items) for patients with asthma, CHD, COPD, diabetes, hypertension, LVD and stroke. For patients with cancer, only a record of smoking status is currently required.

Smoking status of all patients can also be recorded on the basic values screen. However, much more detailed information on smoking can be recorded for all patients via the smoking screens and we recommend that health professionals in primary care should complete these for all patients who smoke.

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Session Date 12/02/2004
Cert.
Contract / SPICE-PC Management of Asthma
Enter dates via ellipse buttons (if not today) or date boxes
About
C Smoking status
Current smoker
C Health ed. - smoking
Trigger factors and their avoidance discussed
Asthma medication review
Management Plan given (written)
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Clinical
Referral
Prescriptions
Screening
Read Code Description
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Date Recorded
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Extension
Start Date
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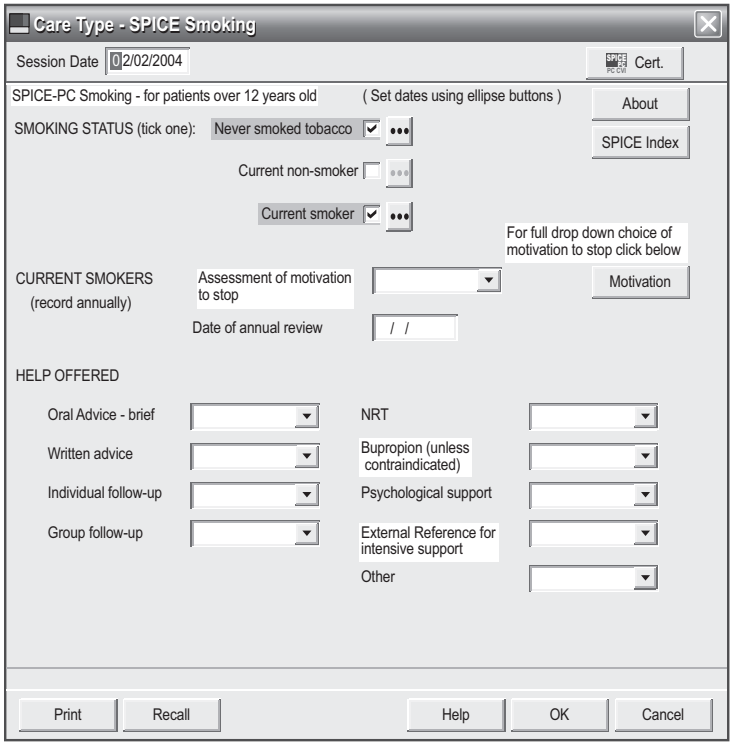
Add...
Modify...
Delete
Formulary...
Immunisation status:
C Influenza
Influenza vaccination
Pneumococcal
Index
Previous
Print
Recall
Help
OK
Cancel


Care Type - SPICE Smoking
Session Date 02/02/2004
Cert.
SPICE-PC Smoking - for patients over 12 years old
(Set dates using ellipse buttons)
About
SMOKING STATUS (tick one):
Never smoked tobacco
SPICE Index
Current non-smoker
Current smoker
For full drop down choice of motivation to stop click below
CURRENT SMOKERS
(record annually)
Assessment of motivation to stop
Motivation
Date of annual review
/ /
HELP OFFERED
Oral Advice - brief
Written advice
Individual follow-up
Group follow-up
NRT
Bupropion (unless contraindicated)
Psychological support
External Reference for intensive support
Other
Print
Recall
Help
OK
Cancel

Appendix 3:

Understanding Addiction to Cigarettes

- Addiction is a condition in which an individual has *impaired control over a behaviour*, with *harmful results* — it is not simply a physical need to maintain levels of a drug to avoid withdrawal symptoms.
- Cigarettes deliver nicotine to the brain very rapidly via the pulmonary circulation.
- Nicotine in mammals binds to acetylcholine receptors in, amongst other regions of the central nervous system, the *ventral tegmental area*.
- This leads to bursts of firing by cells in the *mesolimbic dopamine pathway* and release of a neurotransmitter called *dopamine* in the *nucleus accumbens*.
- This represents a basic '*teaching signal*' which in effect tells the animal to repeat the action that immediately preceded it.
- Thus nicotine is tapping into a basic and ancient '*reward pathway*' which evolved to enable animals to learn to adapt to a complex environment.
- In the language of behavioural pharmacology, nicotine acts as a '*primary positive reinforcer*'.
- Nicotine ingestion also leads to *neuroadaptation* so that when the body becomes depleted of nicotine, a range of unpleasant physical and psychological withdrawal symptoms emerges.
- These include *hunger, aggressiveness, depressed mood, difficulty concentrating*, and *restlessness*. Smokers also experience strong *urges to smoke*. These symptoms are relieved by smoking a cigarette. This in effect 'teaches' the smoker to smoke in the presence of such symptoms in a manner that is parallel to that which occurs with positive reinforcement. This process is referred to as '*negative reinforcement*'.
- The positive and negative reinforcing effects of nicotine, together with the *social rewards* and *environmental triggers* that pervade the smoker's life, form the foundation for addiction to cigarettes.
- As a result, *fewer than 5% of unaided attempts to stop smoking succeed long term* and only about 25% last more than a week.

Appendix 4:

Summary of Case Studies

NHS Board	Name of Service/Project	Case Study
NHS Argyll & Clyde **Contact:** Ann Bryce Tel: 0141 842 7248	CATCH (Community Action on Tobacco for Children's Health)	A service within a hospital maternity unit targeting pregnant smokers
NHS Borders **Contact:** Jo Highet Tel: 01835 824485	Smoking Awareness Service SHAW (Scotland's Health at Work)	A service based in the workplace
NHS Dumfries & Galloway **Contact:** Trish Grierson Tel: 01556 502386	Smoking Matters Service	A specialist service within primary care, also illustrates the use of a Patient Group Direction (PGD)
NHS Fife **Contact:** Nicola Connor Tel: 01592 715213	Kirkcaldy Levenmouth LHCC Smoking Cessation Service	A service working in partnership with the Acute Sector
NHS Forth Valley **Contact:** Kate Johnstone Tel: 01786 463 031	Smoking Cessation Service	A service offering a flexible self-referral system to attract low-income smokers
NHS Greater Glasgow **Contact:** Scott Bryson Tel: 0141 201 4444	Starting Fresh with the Glasgow Pharmacy Stop Smoking Project	A service involving community pharmacies
NHS Grampian **Contact:** Janine Langler Tel: 0500 600 332	Smoking Advice Service	A comprehensive, evidence-based service — example of good practice

Continued ⇢

Appendix 4:

Summary of Case Studies — continued

NHS Board	Name of Service/Project	Case Study
NHS Lanarkshire **Contact:** John Boswell Tel: 01698 281 313	Smoking Cessation Service	This case study is an example of a smoking cessation strategy at NHS Board level
NHS Orkney **Contact:** Aileen Laird/ Mary Ann Crook Tel: 01856 870690	The Stop Smoking Service	A service operating in a remote and rural islands archipelago
NHS Tayside (1) **Contact:** Bill Edwards Tel: 01382 424053	Smoking Cessation (Angus LHCC)	This case study illustrates how trained sessional staff can complement specialist staff in times of high demand
NHS Tayside (2) **Contact:** Bill Edwards Tel: 01382 424053	Special Study Module for Medical Students: Smoking — the role of health promotion	This case study describes an optional smoking module for medical students

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