Public Health Programme Guidance

Smoking cessation in secondary care –acute and obstetric services- Consultation on Draft Scope Stakeholder Comments Table 1st -29th September 2011

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Stakeholder Organisation	Section Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Bolton Hospitals NHS Trust	General	There are varying levels of smoking cessation input required in hospitals. Basic identification and signposting or referral (Level I) and also a more reactive level of assessing motivation to quit and responding with a tailored quit programme that commences soon after the assessment. (Level II). This intervention increasingly should pay attention to the fact that smoking is one of many lifestyle risk factors which contribute significantly to poor health outcomes. Any assessment for smoking individually will be under pressure to allow time for other health issues such as alcohol and diet, physical activity. Developments in smoking cessation will need to move along with other lifestyle health pressures in order not to marginalise itself in accessing hospital staff time for training and subsequent interventions. It is well advised that hospital based practices are well linked to community stop smoking services. There is a real danger of leaving the patient on the doorstep when being discharged with some smoking cessation interventions if they are not proactively followed up by community based services. It is fairly easy for community SS services to monitor electronically the admission status of people it knows to have been assessed for smoking cessation. This means that ongoing care can be kept in place straight from	Thank you for taking the time to read the draft scope and for these helpful comments. The Committee responsible for developing the guidance and recommendations. The Committee will be discussing these issues and considering a range of effectiveness and cost effectiveness evidence. We cannot pre-empt their deliberations at this stage. . There will be an opportunity for all stakeholders to comment on the draft guidance when it is issued for consultation in April – June 2013.

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		discharge. Smoking cessation intervention notification will ideally occur before the patient is discharged or at least around the time of discharge. Ideally only a few days will elapse before the patient is contacted for follow up. Hospital staff need to be convinced of the usefulness of the stop smoking intervention. This ensures it will be delivered in the face of other pressures and also done with some belief. There can be financial penalty or reward drivers introduced to ensure staff are trained to intervene and assessments are completed but still the need for effective training remains in order to ensure the pathway is acceptable to staff and patients. NRT products need to be on formulary for all potential quitters. Whilst in many case combination therapy may not be required the option should be available for heavier smokers or those with more complex needs.	
Bolton Hospitals NHS Trust		The availability of Champix should also be on hospital formularies. There may be some clinical areas where it is not appropriate but these can be easily identified and managed so as not to preclude overall the opportunity to use an agreed first line drug to many smokers. Some of whom may not engage with services again and the opportunity lost. It also seems inequitable that hospital	Noted, thank you. See above.

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		based smokers are offered less options to help them quit than if they were seeking help in the community.	
Bolton Hospitals NHS Trust	General	There is a perception that enforcing smokefree site policies will result in high levels of conflict and/or aggression. This means most policies are not effectively enforced and there impact is variable. We have produced some practice advice on this and can train staff to enforce policy effectively and minimise the potential for conflict. In practice we found that a nurse rated most of her 70 smokefree site policy enforcement encounters as: Good **56** Fair **12** Bad **2.** Project summary form attached..  MARY'S AUDIT - FIRST DRAFT REPOR	The Committee will consider the available evidence on smoke-free strategies and interventions, including factors that act as barriers and facilitators. Please note that the comment form advises you that "comments forms with attachments such as research articles, letters or leaflets cannot be accepted. If comments forms do have attachments they will be returned without being read" This report will be removed when the response table is published on the NICE website It is likely that there will be a call for evidence at a later stage in the guidance development process which will provide details of the evidence we will

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			be requesting.
Bolton Hospitals NHS Trust	General Question 1a	**Many of the key questions asked here may have answers found in my submission to the NICE shared learning website regarding hospital based smoking cessation. This has recently been updated with current activity and practice data.** http://www.nice.org.uk/usingguidance/sharedlearningimplementingniceguidance/examplesofimplementation/eximpresults.jsp?o=502 It is unlikely that to date any implemented hospital based smoking cessation pathway will have included any specific measures to determine cost effectiveness. It is likely that any system that is in place will have been put in place using the historical cost effectiveness data provided by empirical data provided over the last 10-12 years. It is expected that none of them could provide more than costs to run the service including provision of NRT and staff. Some hospitals pay for dedicated staff to deliver others use existing hospital staff to deliver. These two systems would provide very different costing to work out a cost per quitter. It is likely that cost effectiveness is similar to the intervention applied to any smoker who wants to quit and accesses a stop smoking	Thank you. Your link to the shared learning practice database has been noted. Thank you for your comments. Your concerns are noted. We will identify the best available cost effectiveness evidence and will also model the cost effectiveness of specific interventions in order to answer the questions.

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		service. It may be seen that delivering such an intervention in a hospital setting could be more cost effective than the mainstream route accessing community services if using existing hospital staff. This could be due to such things as the absence of publicity, premises, dedicated staff, staff travel etc costs when initial part of the quit attempt is managed in hospital by hospital staff.	
Bolton Hospitals NHS Trust	Question 1b Question 1b subsidiary question	We feel that temporary abstinence is a necessary adjunct to a smokefree hospital site policy. Many such policies would be unworkable if an offer to manage a smokefree hospital stay outside of a definite quit attempt was not available. We have found that quite a few patients who decided to attempt to remain smokefree for their hospital admission but without intention to quit permanently have, when followed up, been keen to maintain their quit attempt. This would prove cost effective as a means to create a quitter as for example two weeks of NRT supplied for temporary abstinence would cost in the region of £16.00. Compare this to the recruitment and management of a potential quitter in the community. We tend to see a more successful four week quit profile in hospital inpatients from cardiology/coronary care wards than respiratory wards or other ward types. Perception is that either the reason to quit is stronger in	Thank you for these suggestions. We cannot pre-empt the deliberations of the Committee responsible for developing the guidance and recommendations. These issues may be included in the guidance, depending on the evidence available. There will be an opportunity for all stakeholders to comment on the draft guidance later in the process.

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		people who have suffered a cardiac event than a respiratory one or the stop smoking interventions are delivered better in some departments than others, though we have not explored this. We tend to believe that hospital based staff smoking interventions may be more acceptable to patients as the relationships are established more quickly after admission and over a longer time period so the intervention can be done at a time when the nurse assesses it's the best time and there is less need for an additional person to be introduced to and involved in the overall care package.	
Bolton Hospitals NHS Trust	General	There needs to be some acknowledgement of the impact of inpatients going outside to smoke. Whilst questions here (6 & 7) ask about nicotine intake and impact on meds and mental physical health of patients it is generally thought drug interactions are minimal and rare and that withdrawal from nicotine does not lead to severe acute physical reactions. Being deprived of what is perceived by the patient to be a self medication for mental or physical issues can cause mental distress and needs to be managed appropriately. Patients going off ward and outside to smoke will probably have more effect on meds and physical and mental health as they are then exposed to a range of dangers such as falls and also possible infections. They may miss ward rounds or appointments for investigations or treatments.	Thank you, noted.
British Dental	general	The BDA supports measures to promote cessation of	Thank you for taking the time to

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Association		tobacco products at every opportunity. We believe that effective communication with tobacco users, and other at risk populations, is of paramount importance. Dental professionals are aware of the dangers of tobacco use and, when able, provide appropriate brief smoking cessation advice and referrals. Embedding the identification and referral of smokers into secondary care could be a step forward in helping those who wish to curtail their tobacco use especially if effective treatment is not routinely offered to populations utilising these services. A concern is that professionals within health services are often working to their full capacity, in sometimes not ideal conditions, and may not be able to bear the burden of the necessary additional training and responsibilities. The cost implications and division of labour for such an embedding also needs to be explored. Attempts to identify smokers with a view to refer them for cessation services could stop patients from seeking and/or accessing medical care due to the sensitive nature of the subject, which in itself could have undesirable outcomes. When smoking cessation advice and interventions are offered and provided it is important that healthcare professionals give a consistent message to those who are in receipt of such services and that the methods being used are all inclusive. It is essential that the message all smokers take away with them is that only	read and comment on the draft scope. Thank you for these helpful comments. We expect the Committee responsible for developing the guidance and recommendations will discuss these issues as well as considering a range of effectiveness and cost effectiveness evidence. We cannot pre-empt their deliberations at this stage. There will be an opportunity for all stakeholders to comment on the draft guidance later in the process, in April -June 2013. Please note, tobacco harm reduction is beyond the scope of this guidance but will be

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		complete cessation will do. Cutting down on the number of cigarettes smoked or changing to a lower-tar brand will not in itself yield a significant health benefit with smokers compensating for the reduced number or type of cigarettes by smoking each cigarette more intensively. Identification of the features of a successful and cost effective cessation program would be beneficial as would methods of increasing the attractiveness of such interventions to target populations to increase uptake.	covered in NICE public health guidance on 'Tobacco: harm reduction approaches to smoking', see: http://guidance.nice.org.uk/PHG/Wave23/23
Cheshire and Merseyside Public Health Network	General	ChaMPs recommend that smoking cessation for acute and obstetric services be viewed as an important component of hospital public health policy and clinician training. That preventative care (which may only comprise of a very brief piece of advice in relation to smoking) is a regular part of any consultation with an inpatient or service user from all clinicians and forms part of their training, ongoing professional development and hospital policy. ChaMPs recommend that it be included in CQUIN targets if effectiveness and cost effectiveness of hospital services is to be addressed adequately for total patient and service user care.	Thank you for taking the time to read and comment on the draft scope. The Committee responsible for developing the guidance and recommendations will be discussing these issues and considering a range of effectiveness and cost effectiveness evidence. We cannot pre-empt their deliberations at this stage. These issues may be included in the guidance, depending on the evidence available. There will be an opportunity for all stakeholders to comment on

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			the draft guidance later in the process.
Cheshire and Merseyside Public Health Network	General	ChaMPs recommend that throughout the document reference to who the guidance will cover should also specify 'out of area patients and service users.' We have been particularly concerned with this issue across Cheshire and Merseyside and have now adopted an 'out of area' policy which achieves equitability and accessibility for all.	Thank you. All patients and service users are included in the scope of the guidance. Regarding out of area patients, Appendix B of the scope lists potential considerations that the committee will take into account, including 'are the interventions available and accessible to different groups?'
Cheshire and Merseyside Public Health Network	General	ChaMPs advise that the availability of pharmacotherapy products also be included within the third bullet of 'subsidiary questions.'	Thank you for your comment. If there is any evidence on the effect of availability of pharmacotherapy it would be addressed by 'Question 5: what barriers and facilitators affect the delivery of effective interventions'.
Cheshire and Merseyside Public Health Network	Section 2 d)	ChaMPs advise that the word 'consultants and all community staff' should be included in the list of people that the guidance is aimed at.	Thank you for your comment. Consultants and community staff are an important audience of the guidance. It is not possible to produce an exhaustive list of all those for whom the guidance is intended.

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			.
Cheshire and Merseyside Public Health Network	Section 4.1.1	Second bullet point – ChaMPs advise that 'parents/family members' of a child that is attending the hospital should also be included in the wording of this document.	Thank you for your comment. Parents and family members of children who are patients or outpatients are included in the scope.
Cheshire and Merseyside Public Health Network	Section 4.1.1	ChaMPs recommend that the words 'teenage pregnant women' should also be included in the final sentence which highlights which groups the guidance will focus on specifically.	Thank you for your comment. The scope has been appropriately amended.
Cheshire and Merseyside Public Health Network	Section 4.1.2	ChaMPs recommend that people with a mental health condition be included within groups as one in four people are living with this illness and therefore should be included within the guidelines for acute and obstetric services. Mental health should not be treated separately.	Thank you for your comments. Complementary guidance on 'smoking cessation in mental health services' will be developed at the same time as the current guidance in acute and obstetric services (see http://guidance.nice.org.uk/PHG/Wave23/26). By developing two pieces of guidance we will be able to devote more attention to the , significant health inequalities for people with mental health problems and the smoking-related issues that are particular to mental health

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			services..
Cheshire and Merseyside Public Health Network	Section 4.2.1 a)	ChaMPs advise that the word 'Brief Intervention' needs to be included as part of the classification of smoking cessation interventions.	Thank you for your comment. We will include evidence that will inform guidance development for all smoking cessation interventions in secondary care settings, including brief interventions.
Cheshire and Merseyside Public Health Network	Section 4.2.1 b)	ChaMPs advise that specific reference be made to illegal tobacco and sale of tobacco being prohibited as part of smokefree policy. We also recommend that smokefree policies include interventions in order to protect community staff visiting clients in their homes, from the damaging effects of secondhand smoke. We have addressed this issue in Cheshire and Merseyside with the development of the Mersey Charter and Cheshire Charter which requires an organisation request that clients 'provide a room that has been smokefree for at least 30 minutes prior to a visit from community staff.' Main entrances also need to be addressed especially due to the numerous problems that have arisen on a national basis.	Thank you for these suggestions. We cannot pre-empt the decisions of the advisory committee that will develop the guidance, but it will be looking at a range of evidence and will consider recommendations for home visits to patients and other service users. There will be an opportunity to comment on the draft guidance when it is issued for consultation in April -June 2013.
Cheshire and Merseyside Public Health Network	Section 4.2.2	ChaMPs query why the guidance will not make reference or cover programmes or interventions aimed at preventing the uptake of tobacco use?	Thank you. We appreciate the importance of interventions aimed at preventing the uptake

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			of tobacco. However the referral from the Department of Health asked NICE to develop guidance for smoking cessation in secondary care. It would not be possible to extend this remit to cover prevention. The scope for the guidance must be achievable within the available time and resources. Future guidance for secondary care settings may cover this topic.
Cheshire and Merseyside Public Health Network	Question 1b	ChaMPs advise that this question include support to quit 'prior to hospital admission and not just in acute and obstetric care settings.	Thank you. This was always our intention. The scope has been appropriately amended to make this clear.
Cheshire and Merseyside Public Health Network	General	Expected outcomes: ChaMPs advise that the wording of acute and obstetric services should be promoted and promoting themselves as models of good practice in line with compliance with smokefree policy.	Noted, thank you
Cheshire and Merseyside Public Health Network	General	ChaMPs advise that there should be an increase in the number of community staff protected from secondhand smoke due to an intervention such as the Mersey and Cheshire Charters; effectively an extension of	There will be a call for evidence during the guidance development process when we will request full details of any

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		smokefree policy.	research that you are aware of that may be relevant to this programme of work.
Cheshire and Merseyside Public Health Network	Question 3	ChaMPs advise that either as part of this question or as a separate question there needs to be reference made to how smoking cessation and intervention advice can be and should be included as part of clinician and health care staff training. The feasibility of inclusion within CQUIN targets needs to be considered.	Thank you, noted. It is anticipated that question 3 would address the issues you identify. The question in the scope is an overarching one. More detailed research questions will be developed in order to identify the best available evidence to answer this question.
Cheshire and Merseyside Public Health Network	Question 6	ChaMPs advise that the wording 'individual use of pharmacotherapy products' should also be included within the guidance.	We cannot pre-empt the deliberations of the advisory committee that will develop the guidance, but this may be an area for which specific recommendations could be developed. Please note: NICE guidance advises that smoking cessation pharmacotherapies should not be used in combination. See http://guidance.nice.org.uk/PH10/Guidance/pdf/English
Cheshire and	Expected	First bullet – ChaMPs advise that the length of an	Thank you for your comment. It

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Merseyside Public Health Network	outcomes	individuals hospital stay needs to be addressed or included within the wording and specific reference made to the fact that 'maternal' hospital stays are usually shorter and therefore allow for a shorter time for quit.	is not anticipated that the length of the quit attempt will be determined by the length of a hospital stay. Support for a quit attempt may begin following referral to a hospital and continue subsequent to discharge.
Cheshire and Merseyside Public Health Network		Fifth bullet – ChaMPs advise that the word 'outcomes for babies' need to be defined in order to highlight 'what' outcomes are being referred to.	Thank you for the suggestion. The scope has been appropriately amended.
Cheshire and Merseyside Public Health Network	General	ChaMPs recommend that a final bullet point be included to specify that the number of staff trained needs to be increased.	Thank you for your suggestion. Education and training of relevant health professionals might be included in the guidance, depending on the available evidence. Appendix B in the scope lists some potential considerations, which include, 'what knowledge and skills do practitioners need to deliver interventions'.
Cheshire and Merseyside Public Health Network	Question 8 and 9	ChaMPs advise that 'ways of dealing with non-compliance' to smokefree policy need to be addressed. Stance and guidance on 'smoking shelters' also needs to be addressed at this stage.	Thank you. These topics could form the basis of a recommendation depending on the evidence

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			available.
Cheshire and Merseyside Public Health Network	Appendix A	ChaMPs strongly advise that electronic referrals, care pathways and equitability access to formulary be addressed. This has been carried out successfully for all hospitals across Cheshire and Merseyside.	Thank you, noted
Cheshire and Merseyside Tobacco Alliance	General	The CMTA recommend that throughout the document reference to who the guidance will cover should also specify 'out of area patients and service users.' We have been particularly concerned with this issue across Cheshire and Merseyside and have now adopted an 'out of area' policy which achieves equitability and accessibility for all.	Thank you for taking the time to read and comment on the draft scope. All patients and service users are included in the scope of the guidance. Regarding out of area patients, Appendix B of the scope lists potential considerations that the committee will take into account, including 'are the interventions available and accessible to different groups?'
Cheshire and Merseyside Tobacco Alliance	Section 2 d)	– The CMTA advise that the word 'consultants and all community staff' should be included in the list of people that the guidance is aimed at.	Thank you for your comment. Consultants and community staff are an important audience of the guidance. It is not possible to include an exhaustive list of those for whom the guidance is intended..
Cheshire and	Section	Second bullet point – the CMTA advise that	Thank you for your comment.

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Merseyside Tobacco Alliance	4.1.1	'parents/family members' of a child that is attending the hospital should also be included in the wording of this document.	Parents and family members of a child patient or outpatient are included in the scope.
Cheshire and Merseyside Tobacco Alliance	Section 4.1.1	The CMTA recommend that the words 'teenage pregnant women' should also be included in the final sentence which highlights which groups the guidance will focus on specifically.	Thank you for your comment. The scope has been appropriately amended.
Cheshire and Merseyside Tobacco Alliance	Section 4.1.2	The CMTA recommend that people with a mental health condition be included within groups as one in four people are living with this illness and therefore should be included within the guidelines for acute and obstetric services. Mental health should not be treated separately.	Thank you for your comments. Complementary guidance on 'smoking cessation in mental health services' will be developed at the same time as the current guidance in acute and obstetric services. (see http://guidance.nice.org.uk/PHG/Wave23/26). By developing two pieces of related guidance we will be able to devote more attention to the significant health inequalities for people with mental health problems and the smoking-related issues that are particular to mental health services.

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Cheshire and Merseyside Tobacco Alliance	Section 4.2.1 a)	The CMTA advise that the word 'Brief Intervention' needs to be included as part of the classification of smoking cessation interventions.	Thank you for your comment. We will consider evidence that will inform guidance development for all smoking cessation interventions in secondary care settings, including brief interventions.
Cheshire and Merseyside Tobacco Alliance	Section 4.2.1 b)	The CMTA advise that specific reference be made to illegal tobacco and sale of tobacco being prohibited as part of smokefree policy. We also recommend that smokefree policies include interventions in order to protect community staff visiting clients in their homes, from the damaging effects of secondhand smoke. We have addressed this issue in Cheshire and Merseyside with the development of the Mersey Charter and Cheshire Charter which requires an organisation request that clients 'provide a room that has been smokefree for at least 30 minutes prior to a visit from community staff.' Main entrances also need to be addressed especially due to the numerous problems that have arisen on a national basis.	Thank you for these suggestions. We cannot pre-empt the decisions of the Committee that will develop the guidance, but they will be looking at a range of evidence and will consider recommendations for home visits to patients and other service users.
Cheshire and Merseyside Tobacco Alliance	Section 4.2.2	The CMTA query why the guidance will not make reference or cover programmes or interventions aimed at preventing the uptake of tobacco use?	Thank you. We appreciate the importance of interventions aimed at preventing the uptake of tobacco. However the referral from the Department of

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			Health asked NICE to develop guidance for smoking cessation in secondary care. It would not be possible to extend this remit to cover prevention. The scope for the guidance must be achievable within the available time and resources.
Cheshire and Merseyside Tobacco Alliance	Question 1b	The CMTA advise that this question include support to quit 'prior to hospital admission and not just in acute and obstetric care settings.	Thank you. This was always our intention.. The scope has been appropriately amended to make this clear.
Cheshire and Merseyside Tobacco Alliance	General	Expected outcomes: the CMTA advise that the wording of acute and obstetric services should be promoted and promoting themselves as models of good practice in line with compliance with smokefree policy.	Noted thank you
Cheshire and Merseyside Tobacco Alliance	General	The CMTA advise that there should be an increase in the number of community staff protected from secondhand smoke due to an intervention such as the Mersey and Cheshire Charters; effectively an extension of smokefree policy.	There will be a call for evidence during the guidance development process when we will request full details of any research that you are aware of that may be relevant to this

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			programme of work
Cheshire and Merseyside Tobacco Alliance	General	We advise that the availability of pharmacotherapy products also be included within the third bullet of 'subsidiary questions.'	Thank you for your comment. If available, this information will be retrieved as part of the detailed searches and research questions for the evidence reviews. The framework of questions outlined in the scope illustrates the questions and outcomes to be considered and was not intended to be exhaustive.
Cheshire and Merseyside Tobacco Alliance	Question 3	The CMTA advise that either as part of this question or as a separate question there needs to be reference made to how smoking cessation and intervention advice can be and should be included as part of clinician and health care staff training. The feasibility of inclusion within CQUIN targets needs to be considered.	Thank you, noted. The question in the scope is an overarching one. More detailed research questions will be developed in order to identify the best available evidence to answer this question. .
Cheshire and Merseyside Tobacco Alliance	Question 6	The CMTA advise that the wording 'individual use of pharmacotherapy products' should also be included within the guidance.	We cannot pre-empt the deliberations of the advisory committee which will develop the guidance, but this may be an area for which specific recommendations could be developed.

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			Please note: NICE guidance advises that smoking cessation pharmacotherapies should not be used in combination. See http://guidance.nice.org.uk/PH10/Guidance/pdf/English
Cheshire and Merseyside Tobacco Alliance	Expected outcomes	First bullet – the CMTA advise that the length of an individuals hospital stay needs to be addressed or included within the wording and specific reference made to the fact that 'maternal' hospital stays are usually shorter and therefore allow for a shorter time for quit.	Thank you for your comment. This section concerns expected outcomes of interventions. However, the length of a hospital stay may be a factor that supports or prevents effective implementation.
Cheshire and Merseyside Tobacco Alliance		Fifth bullet – the CMTA advise that the word 'outcomes for babies' need to be defined in order to highlight 'what' outcomes are being referred to.	Thank you for the suggestion. The scope has been appropriately amended.
Cheshire and Merseyside Tobacco Alliance	General	The CMTA recommend that a final bullet point be included to specify that the number of staff trained needs to be increased.	Thank you for your suggestion. Education and training of relevant health professionals may be an area that could form the basis of a recommendation depending on the evidence available. Under Appendix B we list some potential

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			considerations, which include, 'what knowledge and skills do practitioners need to deliver interventions'.
Cheshire and Merseyside Tobacco Alliance	Question 8 and 9	The CMTA advise that 'ways of dealing with non-compliance' to smokefree policy need to be addressed. Stance and guidance on 'smoking shelters' also needs to be addressed at this stage.	Thank you. These topics could form the basis of a recommendation depending on the evidence review.
Cheshire and Merseyside Tobacco Alliance	Appendix A	The CMTA strongly advise that electronic referrals, care pathways and equitability access to formulary be addressed. This has been carried out successfully for all hospitals across Cheshire and Merseyside.	Thank you, noted
Cheshire and Merseyside Tobacco Alliance, (CMTA)	General	The CMTA recommend that smoking cessation for acute and obstetric services be viewed as an important component of hospital public health policy and clinician training. That preventative care (which may only comprise of a very brief piece of advice in relation to smoking) is a regular part of any consultation with an inpatient or service user from all clinicians and forms part of their training, ongoing professional development and hospital policy. The CMTA recommend that it be included in CQUIN targets if effectiveness and cost effectiveness of hospital services is to be addressed adequately for total patient and service user care.	These issues may be included in the guidance, depending on the evidence available. At this stage we cannot pre-empt the deliberations of the Committee responsible for developing the guidance and recommendations. There will be an opportunity for all stakeholders to comment on the draft guidance in April- June 2013.

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Croydon PCT		The routine use of NRT for inpatients that normally smoke, coupled with opportunistic brief interventions, should be broadened.	Thank you for taking the time to read and comment on the draft scope. These issues may be included in the final guidance, depending on the evidence available. We cannot pre-empt the deliberations of the Committee responsible for developing the guidance and recommendations. There will be an opportunity for all stakeholders to comment on the guidelines later in the process.
Croydon PCT		Visitors sometimes encounter awareness stands from the local Stop Smoking Service in the hospital foyer but other than this there is no system for identifying smokers among visitors (other than observing them smoking on site – as already stated this generally does not result in a challenge much less a brief intervention discussion).	Thank you, noted.
Croydon PCT		Staff clinics are publicised and offered and have had some success. However smoking stills sees to be more socially acceptable among hospital staff than in some other contexts.	Thank you, noted.
Croydon PCT		Largely ineffective in terms of compliance with NHS	Thank you, noted.

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		smokefree policies i.e. people nip outside the building and smoke unchallenged – even when standing next to smokefree signage.	
Croydon PCT	**SECTION 4.3 Question 1b:** How effective and cost effective are interventions for temporary abstinence from smoking in acute and obstetric care settings?	Smokefree policies for hospitals appear to be poorly implemented in many cases. The use of smoking areas outside hospital buildings but still on hospital grounds continues, with flagrant disregard for signage both from staff, patients and visitors. No challenging or policing appears to take place. Smoking prevalence among hospital staff appears relatively high and so challenging patients and visitors when colleagues are visibly flouting the policy can be problematic for staff. The culture seems to be that there are more important things to think about, and many acute care staff still seem to struggle with illhealth prevention approaches.	Thank you for your comments and these helpful observations..
Croydon PCT	**SECTION 4.3**	It should be a disciplinary matter when staff flout NHS policies. This would reduce staff visibly smoking, which	Thank you for these suggestions.

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	Question 10: What are the barriers and facilitators affecting compliance with smokefree policies in acute and obstetric care settings? What are the views, perceptions and beliefs of acute and obstetric care staff, patients,	would empower other staff to challenge smokers and deliver brief interventions. If a smoker witnesses others smoking in a no-smoking area, including staff from the hospital, they will of course assume that it is acceptable to smoke too. De-normalisation is necessary.	See above.

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	service users and visitors?		
Croydon PCT	**SECTION 4.3 Question 2a:** How effective and cost effective are the current approaches used by acute and obstetric care services to identify and refer people from the groups listed in 4.1.1 to	Patchy. Patients are routinely asked about smoking status but a brief intervention does not necessarily follow. Anecdotally, many staff feel that smoking cessation advice is invasive and are reluctant to challenge people. In our local hospital no facility exists on the hospital Patient Administration System for recording referrals to Stop Smoking Services or outcome. This makes audit, and consequently effective implementation, extremely difficult.	Thank you for your comments. Your concerns are noted. These questions will inform the research questions for the reviews of the evidence of effectiveness and cost effectiveness identified from a range of sources, including reviews of perspectives of practitioners and service users. All of this evidence will inform the development of the guidance.

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	stop-smoking services?		
Croydon PCT	**SECTION 4.3 Question 3:** What approaches are an effective and cost effective way to encourage acute and obstetric care professionals to record the smoking status of the groups	Initiatives such as CQUINs which incentivise implementation of screening and referral systems can have some success, but a culture shift in Acute and Obstetrics is required to be most effective. An embedded systemic screening and referral mechanism should be implemented mandatorily to facilitate this	Thank you for this suggestion. The scope sets out the overarching questions. Each overarching question is underpinned by a set of detailed research questions covering a range of issues including type of approaches to encourage staff. As far as the evidence allows the review will address these detailed questions as they are crucial to the process of developing recommendations.

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	listed in 4.1.1, offer them smoking cessation information, advice and support or refer them to stop-smoking services?		
Croydon PCT	**SECTION 4.3 Question 4:** How can community, primary, acute and obstetric care	Stop Smoking Services must facilitate a highly active local network to achieve this. Newsletters, performance benchmarking, validation for high performers and site visits to partners who need support would help.	Thank you, noted.

Stakeholder Organisation	Section Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
	providers collaborate more effectively to provide seamless smoking cessation services?		
Croydon PCT	**SECTION 4.3 Question 5:** What barriers and facilitators affect the delivery of effective interventions?	Barriers include a poor culture in hospitals around: • Challenging what is seen as a personal choice – smoking. • Using illhealth prevention approaches. • Considering smoking a 'normal' and acceptable behaviour among staff, patients and visitors.	Thank you, noted.
Croydon PCT	**SECTIO**	Largely effective in terms of compliance with the law	Thank you, noted.

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	N 4.3 Question 8: How effective and cost effective are strategies and interventions for ensuring compliance with smokefree legislation and local smokefree policies in acute and obstetric care settings?	around smokefree spaces i.e. people do not generally smoke in the hospital buildings.	

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Croydon PCT	**SECTION 4.3 Question 9:** Are there any unintended consequences from adopting smokefree approaches in acute and obstetric care settings?	Yes, smoking inpatients must be cared for. The routine use of NRT for inpatients must be encouraged as they cannot generally leave the site to smoke and the unpleasant effects of nicotine addiction must be ameliorated.	Thank you, noted.
Dept of Health	General	We welcome this draft scope, because it covers a very important area. Definitive guidance on the effectiveness and cost-effectiveness of the various aspects of smoking cessation services are important and highly relevant in the current economic climate.	Thank you for taking the time to read and comment on the draft scope.
Dept of Health	General	We are pleased that the questions include searching for evidence on the effects of nicotine intake or patients and	Thank you.

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		users of services.	
GASP	General	Good overall summary of the problem and the need for guidance. I was surprised by some of the stats. Are only 5% of hospital admissions smoking related? Seems low.	Thank you for taking the time to read and comment on the draft scope. Yes, 5% is based on the current, available data from the NHS Information Centre.
GASP	General	There is no specific mention of good resources targeting smokers with different conditions. GASP produces a very popular 'Stop Before your Op', Smoking and Cancer Treatment, Smoking and Diabetes, Smoking and Impotence, Sex and the Ciggie, Pregnant? That's Two Good Reasons to Stop Smoking, Smoking and Asthma, and other about eyes, bones, lungs heart etc etc. You mention 'information' but well targeting information is essential to reinforce health professionals' advice.	Thank you, noted. We cannot pre-empt the deliberations of the Committee responsible for developing the guidance and recommendations. These issues may be included in the final guidance, depending on the evidence available. However, there will be an opportunity for all stakeholders to comment on the draft guidance later in the process.
GASP	3f	I find it contradictory when the 'only' answer to 67% of smokers wanting to quit is to refer them to NHS stop smoking services despite so few wanting their smoking to be seen as a clinical problem. The statement '4 times more likely to quit' is very misleading as the vast majority of smokers quit on their own. The 4 times more likely to quit is for 4 week quitters and do not represent long term quitters. In both California and Australia	Thank you for your comments. Your concerns are noted. The guidance will be informed by evidence of effectiveness and cost effectiveness identified from a range of sources, including evidence of different intervention types in secondary

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		where they mainly use 'denormalisation' strategies and lots of media ads to show the risk of smoking, the smoking rates are much lower. As an ex-smoker I would not have used the services. There are those who do and it is a very useful resource but smokers are NOT helped when they are told not to bother trying to quit themselves as they are likely to fail and only those who go to the NHS services are in with a chance. Not true!	care, with different definitions of quit attempts. It will also be informed by evidence of perspectives of practitioners and service users. The committee responsible for developing the guidance may ask for evidence of the type of strategies you outline, that may be relevant to secondary care settings.
GASP	3g	Despite smokefree policies smoking on NHS premises is still a huge problem with poor enforcement. 2 positive moves for good enforcement are: 1) A training video made by Blackpool PCT for hospital and all NHS staff to challenge and enforce the policy when they see smokers lighting up and 2) In Dundee the security office for the hospital site was trained to approach visitors and patients he saw smoking and offer them a breath CO monitor check. For anyone interested he would offer them stop smoking advice and referral.	Thank you for this comment. There will be a call for evidence later in the guidance development process. it may include a call for evidence of evaluations of smoke-free strategies.
GASP	4.1	Group to be covered should also include policy makers that create the ethos of a hospital etc. Many years ago a survey run by the HEA scored hospitals and health trusts a maximum of 5 stars if they complied with a range of tobacco control measures. The results were publicised and when the survey was repeated, policy	Thank you for your comments. Please note, section 4.1 covers groups that the evidence will and will not cover – in this instance they are people who smoke.

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		makers were mad keen to win a '5 star' rating in the follow up survey. I think this approach could be applied to smoking cessation and smokefree policy implementation.	Please see section 2d which explains the audiences for the guidance.
GASP	4.2.1 a	If patients don't want to be referred they can also be offered motivation and confidence that they many smokers do it themselves without medication. A great way doing this is to have a collection of case study stories of patients etc who have quit using a range of methods – including on the own with or without NRT. There is nothing like telling Billy Bloggs that a person just like him quit using X, Y and Z. Very few departments gather up success stories to inspire other patients with. Smokers need motivation and hope to achieve success.	Thank you, noted. See response above.
GASP	4.2.1.b	See above for suggestions of broadening out the responsibility for enforcing smokefree policy. But the more people standing about at hospital entrances unchallenged the more it continues.	Thank you for your comment.
GASP	4.3 1a	Not very. Not a high priority. I recently sat in a pre-op clinic and heard every person there being asked if they smoked and told it wasn't a good idea. The NHS stop smoking service was in the building next door and not one person was referred or was given advice on quitting. There are excellent exceptions.	Thank you for your comment, noted. The scope sets out the overarching questions. Each overarching question is underpinned by a set of detailed research questions The evidence reviews will address these detailed

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			questions to inform the development of the recommendations.
GASP	1.b	All of the listed reasons have impact but no mention was made of back up information and use of case studies and testimonials of smokers who had quit from different groups of patients and similar social class and age etc. The reinforcement of an intervention with a media message is essential to create a societal impact.	Thank you for these suggestions. See comments above regarding case studies and testimonials. Media messages are beyond the scope of this guidance. It is important to produce a scope that is achievable within the available time and resources. However, future guidance for secondary care settings may cover this topic.
GASP	Question 3	Realistic expectations of success (low but will make a difference). For clinicians they feel it is a waste of time to do anything about smoking. If they could have realistic idea of what a 4% change means in public health terms would be so useful!	Thank you for your comment, noted.
GASP	Question 4	Demand more global denormalisation approaches and more optimism about the ability to stop. We give so many smokers the idea that it cannot be done. We need to be upbeat, positive, optimistic and emphasise it is a process and most people have a few goes at it. We disempower smokers more often that inspire them.	Thank you, noted.

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GASP	Question 5	Health staff are not always the best deliverers. In North Somerset they have trained a woman with COPD to help others with COPD to quit. She quit last year and talks the talk of a recent quitter with the powerful message – if I can do it anyone can. And its true. Smokers want to identify with the person giving the message. If not then at least hear the message from a third person ie successful quitters they can relate to. One hospital had a stop smoking group for diabetics. The group then wrote a promotional invite to other diabetics for future groups.	Thank you, noted.
GASP	Question 6	I don't know the answer. But I find the promotion of NRT against the wishes of many smokers who are put off.	Thank you, noted. The review of evidence will include factors that act as facilitators and barriers. Thus, studies on the views and experiences of interventions will be considered for inclusion in the review.
GASP	Question 7	Sometimes a lack of control.	Thank you for your comment.
GASP	Outcomes	Numbers quitting NOT just numbers referred! Better compliance with smokefree policies, numbers of staff who have responsibility for helping smokers.	Thank you. We have asked two questions, one about quit attempts and another about referrals to acknowledge that they may not be recorded as

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			one combined outcome.
Gateshead, south Tyneside and Sunderland Stop Smoking Service (Tier 3 only)	4.3	A question relating to assessing effectiveness of 'blanket' or 'opt out' referral to specialist services would be very useful	Thank you for taking the time to read and comment on the draft scope. If there is evidence of such approaches, these will be considered by the committee that develops the guidance.
Heart of England NHS Foundation Trust	GENERAL	HEFT welcomes the development of this important public health guidance on smoking cessation in secondary care (acute/obstetric services) and is interested in seeing/hearing about how this guidance develops. We look forwards to reading and commenting on further drafts. There are several evidence based papers/clinical cases for smoking cessation in secondary care e.g. oncology, before surgery, pregnant women, paediatrics and wound care (there are others) which may be a useful reference for the programme guidance development group. These were published last year by DH tobacco control team.	Thank you for taking the time to read and comment on the draft scope. There will be an opportunity for stakeholders to comment on the draft guidance during a consultation period, from April to June 2013. There will be a call for evidence later in the guidance development process. Details of any research that may be relevant to this programme of work and that has not been found during the literature searches is likely to be requested.
Heart of England NHS Foundation Trust	SECTION 1d	Is this guidance aimed at the following staff groups? Midwives, maternity support workers, health care	Thank you. The scope, section 2d, has been amended to

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		assistants, obstetricians, sonographers, fertility nurses, gynae nurses (incl., emergency).	include midwives. This section already mentions doctors, nurses and social workers – in addition to all secondary care staff.
Heart of England NHS Foundation Trust	SECTIO N 4.2a	In light of the NICE recommendation to implement routine CO screening at booking for all pregnant women and then appropriately throughout pregnancy, will the PDG give some consideration to encouraging midwives and maternity support workers to review smoking status on all admissions to the antenatal ward/antenatal day unit and offer further CO testing to women who smoke? This is a great opportunity to strengthen CO testing throughout the pregnant woman's pathway to include admissions/ visits to secondary care either as an outpatient or inpatient.	Thank you for these suggestions. We cannot pre-empt the decisions of the Committee that will develop the guidance, but they will be looking at a range of evidence and will consider implementation approaches. There will be an opportunity to comment on the draft guidance.
Heart of Mersey (HoM)	General	HoM recommend that smoking cessation for acute and obstetric services be viewed as an important component of hospital public health policy and clinician training. That preventative care (which may only comprise of a very brief piece of advice in relation to smoking) is a regular part of any consultation with an inpatient or service user from all clinicians and forms part of their training, ongoing professional development and hospital policy. HoM recommend that it be included in CQUIN targets if effectiveness and cost effectiveness of hospital services is to be addressed adequately for total patient	Thank you for taking the time to read and comment on the draft scope. We cannot pre-empt the deliberations of the Committee responsible for developing the guidance and recommendations. These issues may be included in the final guidance, depending on the evidence available and

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		and service user care.	there will however, be an opportunity for all stakeholders to comment on the guidelines later in the process.
Heart of Mersey (HoM)	General	HoM recommend that throughout the document reference to who the guidance will cover should also specify 'out of area patients and service users.' We have been particularly concerned with this issue across Cheshire and Merseyside and have now adopted an 'out of area' policy which achieves equitability and accessibility for all.	Thank you. All patients and service users are included in the scope of the guidance. Regarding out of area patients, Appendix B lists potential considerations that the committee will take into account, including 'are the interventions available and accessible to different groups?'
Heart of Mersey (HoM)	Section 2 d)	HoM advise that the word 'consultants and all community staff' should be included in the list of people that the guidance is aimed at.	Thank you for your comment. Consultants and community staff are an important audience of the guidance. It is not possible however to include an exhaustive list of those for whom the guidance is intended.
Heart of Mersey (HoM)	Section 4.1.1	Second bullet point – HoM advise that 'parents/family members' of a child that is attending the hospital should also be included in the wording of this document.	Thank you for your comment. Parents and family members of a child patient or outpatient are included in the scope.
Heart of Mersey (HoM)	Section 4.1.1	HoM recommend that the words 'teenage pregnant women' should also be included in the final sentence	Thank you for your comment. The scope has been

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		which highlights which groups the guidance will focus on specifically.	appropriately amended.
Heart of Mersey (HoM)	Section 4.1.2	HoM recommend that people with a mental health condition be included within groups as one in four people are living with this illness and therefore should be included within the guidelines for acute and obstetric services. Mental health should not be treated separately.	Thank you for your comments. Complementary guidance on 'smoking cessation in mental health services' will be developed at the same time as the current guidance in acute and obstetric services. (see http://guidance.nice.org.uk/PHG/Wave23/26). By developing two pieces of separate but related guidance we will be able to devote more attention to the significant health inequalities for people with mental health problems and the smoking-related issues that are particular to mental health services.
Heart of Mersey (HoM)	Section 4.2.1 a)	HoM advise that the word 'Brief Intervention' needs to be included as part of the classification of smoking cessation interventions.	Thank you for your comment. We will endeavour to search for evidence that will support

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			guidance development for all smoking cessation interventions in secondary care settings, including brief interventions.
Heart of Mersey (HoM)	Section 4.2.1 b)	HoM advise that specific reference be made to illegal tobacco and sale of tobacco being prohibited as part of smokefree policy. We also recommend that smokefree policies include interventions in order to protect community staff visiting clients in their homes, from the damaging effects of secondhand smoke. We have addressed this issue in Cheshire and Merseyside with the development of the Mersey Charter and Cheshire Charter which requires an organisation request that clients 'provide a room that has been smokefree for at least 30 minutes prior to a visit from community staff.' Main entrances also need to be addressed especially due to the numerous problems that have arisen on a national basis.	Thank you for these suggestions. We cannot pre-empt the decisions of the committee that will develop the guidance, but it will be looking at a range of evidence and will consider recommendations for staff visits to service users at home.
Heart of Mersey (HoM)	Section 4.2.2	HoM query why the guidance will not make reference or cover programmes or interventions aimed at preventing the uptake of tobacco use?	Thank you. We appreciate the importance of interventions aimed at preventing the uptake of tobacco. However it is important to produce a scope that is achievable within the available time and resources.

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Heart of Mersey (HoM)	Question 1b	HoM advise that this question include support to quit 'prior to hospital admission and not just in acute and obstetric care settings.	Thank you for the suggestion. The scope has been appropriately amended.
Heart of Mersey (HoM)	General	Expected outcomes: the HoM advise that the wording of acute and obstetric services should be promoted and promoting themselves as models of good practice in line with compliance with smokefree policy.	Noted thank you
Heart of Mersey (HoM)	General	HoM advise that there should be an increase in the number of community staff protected from secondhand smoke due to an intervention such as the Mersey and Cheshire Charters; effectively an extension of smokefree policy.	Thank you for this comment. If it relevant to the scope of this guidance, we will be interested in any evaluated evidence you may have.
Heart of Mersey (HoM)	General	HoM advise that the availability of pharmacotherapy products also be included within the third bullet of 'subsidiary questions.'	Thank you for your comment. If there is any evidence on the affect of the availability of pharmacotherapy it would be addressed by 'Question 1a: how effective are smoking cessation interventions' and 'Question 5: what barriers and facilitators affect the delivery of effective interventions'.
Heart of Mersey (HoM)	Question 3	HoM advise that either as part of this question or as a separate question there needs to be reference made to	Thank you, noted. It is anticipated that question 3

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		how smoking cessation and intervention advice can be and should be included as part of clinician and health care staff training. The feasibility of inclusion within CQUIN targets needs to be considered.	would address the issues you identify. We will endeavour to identify the best available evidence to answer this question; detailed definitions are more appropriate in the search strategies.
Heart of Mersey (HoM)	Question 6	HoM advise that the wording 'individual use of pharmacotherapy products' should also be included within the guidance.	We cannot pre-empt the deliberations of the committee, but this may be an area for which specific recommendations could be developed. Please note: NICE guidance advises that smoking cessation pharmacotherapies should not be used in combination. See http://guidance.nice.org.uk/PH10/Guidance/pdf/English
Heart of Mersey (HoM)	Expected outcomes	First bullet – HoM advise that the length of an individuals hospital stay needs to be addressed or included within the wording and specific reference made to the fact that 'maternal' hospital stays are usually shorter and therefore allow for a shorter time for quit.	Thank you for your comment. This section concerns expected outcomes of interventions. However, the length of a hospital stay may be a factor that supports or prevents effective implementation.

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Heart of Mersey (HoM)		Fifth bullet – HoM advise that the word 'outcomes for babies' need to be defined in order to highlight 'what' outcomes are being referred to.	Thank you for the suggestion. The scope has been appropriately amended.
Heart of Mersey (HoM)	General	HoM recommend that a final bullet point be included to specify that the number of staff trained needs to be increased.	Thank you for your suggestion. Education and training of relevant health professionals may be an area that could form the basis of a recommendation depending on the evidence review. Under Appendix B we list some potential considerations, which include, 'what knowledge and skills do practitioners need to deliver interventions'.
Heart of Mersey (HoM)	Question 8 and 9	HoM advise that 'ways of dealing with non-compliance' to smokefree policy need to be addressed. Stance and guidance on 'smoking shelters' also needs to be addressed at this stage.	Thank you. These topics could form the basis of a recommendation depending on the evidence review.
Heart of Mersey (HoM)	Appendix A	HoM strongly advise that electronic referrals, care pathways and equitability access to formulary be addressed. This has been carried out successfully for all hospitals across Cheshire and Merseyside.	Thank you, noted

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NCSCT Community Interest Company	4.3, Questions 1a & 1b	Provision of stop smoking support in secondary care is often regarded as a missed opportunity. Smoking increases the risks associated with hospitalisation for surgery and people who are in hospital because of a smoking-related illness are likely to be more receptive to support to stop smoking. Smokers are more likely to experience post-operative complications, increased recovery time, and slower wound healing. This can result in the need for further surgery, a longer hospital stay and increased costs to the health service (Moller at al., 2002). An updated Cochrane review (Rigotti et al., 2008) demonstrates the positive impact of implementing stop smoking services for inpatients. This review of trials found that programmes to stop smoking that begin during a hospital stay and include follow-up support for at least one month after hospital stay are effective. Such programmes are effective when administered to all hospitalised smokers, regardless of admitting diagnosis.	Thank you for taking the time to read and comment on the draft scope. We will endeavour to identify the best available evidence to answer this question. Thank you, noted.
NCSCT Community Interest Company	4.3, Questions 1a & 1b (continued)	To have the greatest chance of reducing smoking-related risks, it is recommended that patients stop smoking as soon as possible prior to surgery. Patients should therefore be advised to stop smoking, and should be offered support to do so, as soon as the need for surgery is decided. However, stopping smoking at any point before, during or after surgery would be of health	Thank you. The scope sets out the overarching questions to be covered in the guidance and the evidence reviews. Each overarching question is

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		benefit to the patient. Patients with an unplanned admission to hospital are particularly receptive to health advice and support while in hospital. Timely stop smoking advice shortly after admission may therefore tap in to this potential period of heightened motivation to stop smoking, encourage smokefree hospital policy compliance and highlight any need for withdrawal management. Many hospitalised smokers are addicted to nicotine and will experience characteristic and potentially significant withdrawal symptoms (including anger, depression, anxiety, impatience, insomnia and restlessness as well as strong urges to smoke) when abstinent from tobacco during the time they are confined in hospital (Hughes 2006, Hughes 2007). In light of all of the evidence (both published and anecdotal), research and guidance in the area of stop smoking support in the hospital setting it is possible to recommend that 'smoking cessation interventions' are broken down into layers, which will have varying degrees of effectiveness both in terms of cost, and take-up of stop smoking support. These layers are: **1. Recording of patient smoking status:**	underpinned by a set of detailed research questions The evidence reviews will address these detailed questions to inform the development of the recommendations.

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		This has two key benefits: • Simply asking the question, 'do you smoke?' acts as an intervention in itself, and has proven to be a trigger for health evaluation and take up of an offer of support and/or triggering a quit attempt.	
NCSCT Community Interest Company	4.3, Questions 1a & 1b (continued)	• By hospital staff recording patient smoking status, they will have a much more accurate picture of their hospital smoking prevalence, and therefore the need for provision of stop smoking support. Patient smoking status is often a smoking related indicator in Commissioning for Quality and Innovation (CQUIN) contracts. It is worth noting that whilst recording of smoking status is very important, the hospital needs the systems in place to be able to record this and subsequently report to the commissioner. 2. Giving 'Very Brief Advice' (VBA), the 30 second 'Ask, Advise, Act' (AAA) approach • All smoking patients should be routinely given VBA, the 30 second AAA approach • Training on how to give VBA should be available to staff and should be mandatory, with an emphasis on this being embedded as part of day-to-day activity and culture within the organisation, and that it is a duty of care to patients which only takes 30 seconds . There will be an NCSCT VBA online training	Thank you. See above response

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		programme available by January 2012. • Giving patients VBA is often included as a smoking related indicator in CQUIN contracts. It is very important to include this, however, as with smoking status, it is also important that the systems exist for staff to be able to record and report that this has taken place 3. Offering the patient a referral to stop smoking support • Smoking patients should routinely be offered a referral to stop smoking support • Frontline staff should be aware and familiar with how to refer smoking patients and systems need to exist to ensure that this can happen efficiently and effectively • As with the above points regarding recording of smoking status and giving VBA, referrals are a most frequently cited smoking related indicator in CQUIN contracts, and systems need to exist to ensure that there is the means to record these referrals, and that they are appropriate referrals, not just every smoker regardless of their interest in stopping smoking and if they are in a stable condition and able to receive stop smoking support.	
NCSCT Community	4.3,	4. Provision of NRT for withdrawal management	Thank you. See above

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Interest Company	Questions 1a & 1b (continued)	during periods of forced abstinence • Provision of NRT for patients should be available on admission, this will ease withdrawal from nicotine and associated symptoms such as irritability and make the patient more comfortable • If a patient is given VBA but declines a referral to the stop smoking service, they should be offered NRT again if they have not taken it up previously • It has been recommended that hospital staff are prohibited from smoking during working hours, and anecdotal evidence has shown this to be successful in some hospitals. If an HR policy states this, the HR team should work in partnership with the local stop smoking service(s) and provide support, and/or suggest that NRT should be available for these periods of forced abstinence, and that NRT should be stocked in the hospital shops for staff to purchase. 5. Stop Smoking Medication being available on the hospital formulary • A good range of NRT products available on the hospital formulary is essential to ensure patient choice, with anecdotal evidence showing that the inhalator is a very popular and effective product for hospital patients. • Champix has been prescribed in many hospitals in	response

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		England, and anecdotal evidence has shown that it is effective. • If a patient is admitted to hospital and is using NRT or Champix as part of a quit attempt it is important that these products are available on the hospital formulary and the patient can continue to use these products whilst in hospital. 6. Stop smoking support Stop smoking support in hospital, for inpatients, as well as outpatients, patients that have a short stay in hospital and hospital staff need to be tailored to suit the needs of the patients, and appropriate support given. There is not a 'catch all' type of support, and will largely depend on the condition and mobility of the patient. Some suggestions and information on current activity are as follows:	
NCSCT Community Interest Company	4.3, Questions 1a & 1b (continued)	Any intervention given should be carried out in line with the NCSCT evidence based competencies for behavioural support and should be guided by the NCSCT standard treatment programme. • **Bedside one-to-one support** An initial contact by an NCSCT trained stop smoking advisor after receiving the referral to discuss support options is a regular feature in hospitals with an appointed advisor. This could also take the form of a	Thank you. See above response

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		phone call to the patient and assessment of the best support for the patient. One-to-one support could then continue at bedside, setting a quit date on the initial appointment or returning the next day. The patient may be discharged soon after the initial conversation, so it is important that the patient is not then 'lost' and is supported to stop smoking when they return home or into a community setting. • **One-to-one clinics** Many services run one-to-one clinics in hospitals, on an appointment basis. This is very popular with outpatients where their stop smoking appointment can coincide with their other hospital appointments. For more mobile inpatients this is also an option to visit the advisor and set a quit date and/or continue support • **Drop-in sessions** Many services also run drop-in sessions in hospitals, which again are very popular with patients and staff due to their flexibility, and also with visitors, which is an area which could be further developed and publicised. • **Regular stop smoking group** Some services run stop smoking groups in hospitals, which are more popular with staff members. Groups are proven to be the most successful option for smokers, however, in a hospital setting this may not	

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		always be the case.	
NCSCT Community Interest Company	4.3, Questions 2a & 2b	There is not a great deal of evidence, and there is a lot of variation in terms of how effective and cost effective the current approaches used to identify, refer and provide patients with smoking cessation information, advice and support are. However, the pre-implementation interim report of the Department of Health's 'Stop Smoking Interventions in Secondary Care' pilot found that in the initial cohort, 30.7% of the hospital population were current smokers, and 8.6% were former smokers who had either recently quit or were abstinent in hospital. Of those who quit, 22.6% reported using their local Stop Smoking Service. 40.7% of smokers reported being given some information or advice about stopping smoking in relation to their hospital admission, but just 18.5% used NRT while in hospital. This indicates that the majority of smokers are not receiving evidence-based interventions to help them to stop and that a significant number of smokers present at secondary care settings. A copy of the full report will be available by the end of October 2011 which I can send over if needed. In addition to this the NCSCT CIC conducted two surveys at the beginning of the year. The first survey was sent to acute trust or local hospital leads for	Thank you for your comment. We will endeavour to identify the best available evidence to answer these questions. There will be a call for evidence later in the guidance development process. Details of any research that may be relevant to this programme of work and that has not been found during the literature searches is likely to be requested.

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		smoking cessation in February 2011. It was a very short survey designed to gather baseline information of smoking related activity within Acute Trusts. There were 32 responses to the survey using the online 'Survey Monkey' questionnaire. The results showed that a low proportion of respondents (22%) knew their smoking prevalence, and there was a wide variation in what this was (from 29% to 8.8%), with an average of 17%. A high proportion of respondents provided patients with support to stop smoking whilst in hospital (81%), and this support was mostly provided by someone that was employed by the local stop smoking service (61.5%).	
NCSCT Community Interest Company	4.3, Questions 2a & 2b (continued)	The majority stated that all patients were routinely given 'very brief advice' (VBA) (77.4%), and that staff were offered training to give VBA. The majority stated that the hospital was engaged with the local stop smoking service(s) (93.8%), over half had a CQUIN contract in place with smoking related outcomes (62.5%) and just under a third had an appointed British Thoracic Society 'Smoking Champion'(28.1%). The results show that there is a need to further develop	Thank you. See above responses.

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		areas of secondary care. The key recommendations are: 1, All patients have smoking status recorded; 2. All patients are given VBA and referred to appropriate support and; 3, VBA training is mandatory for all staff, and that systems exist to make the delivery of VBA possible in day-to-day activity. The second survey was designed to gain a more in depth picture of activity and stop smoking support available within hospitals to inform the development of the NCSCT CIC secondary care project. The survey was aimed at anyone whose work involves stop smoking support in secondary care. There were seventy respondents to the survey, from a variety of roles relating to secondary care. The top-line findings were: 1. The majority of stop smoking advisors working in a hospital were employed by the stop smoking service (74.3%). 2. There was a significant association between those that had a smoking related CQUIN contract and increased activity, increased referrals, an increase in 'very brief advice' training and improved engagement between the primary care trust (PCT) and the acute trust. 3. The majority of respondents identified that the following elements were needed to assist their work in	

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		stop smoking support in secondary care: NRT being available on the hospital formulary (90.7%), training for staff (88.4%), senior management support (87.8%), Board level and PCT / local authority (LA) support (83.7%) and a robust electronic referral system (62.8%).	
NCSCT Community Interest Company	4.3 Question 3	In addition to the response to questions 2a & 2b in terms of the Department of Health's 'Stop Smoking Interventions in Secondary Care' interim report, there is the NCSCT CIC 'Streamlined Secondary Care System' pilot which is aiming to increase identification and referral of smokers in secondary care settings. Please find a summary of this project to date below: **Overview** The NCSCT CIC programme of work involves key projects including developing systems in secondary care. The main element of the secondary care workstream is to pilot a whole hospital approach to stop smoking support for patients, entitled the 'Streamlined Secondary Care System'. The system has a very simplistic and basic approach, including a straightforward electronic referral method and easy to measure 'real time' results, enabling efficient and robust	Thank you. There will be a call for evidence later in the guidance development process. Details of any research that may be relevant to this programme of work and that has not been found during the literature searches is likely to be requested.

Stakeholder Organisation	Section Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
		evaluation. The approach encourages staff to ask and record smoking status for every patient, to give 30 second 'very brief advice' to all smokers and to refer smokers to their local stop smoking service. The approach also includes protocols for patients to be given nicotine replacement therapy for withdrawal management in instances where the patient declines a referral to a stop smoking service.	
NCSCT Community Interest Company	4.3 Question 3 (continued)	Key elements of the approach: • Online training • Routine recording of smoking status, 'very brief advice' and referral • Nicotine replacement therapy protocol for withdrawal management • Stop smoking medicines on the hospital formulary • An electronic referral method • Appropriate stop smoking support **Piloting the approach** The Queen Alexandra Hospital in Portsmouth has been appointed as our pilot site, with Portsmouth and Hampshire as the linked stop smoking services. The system will be piloted in specific departments within the hospital, with an agreement that 75% of staff will	Thank you. See above responses.

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		complete the online training, which includes how to give 'very brief advice', a short assessment, and information about the pilot and how to make a referral. The pilot will start in October 2011 when the electronic referral system becomes active. From October 2011 clinical staff in the pilot departments will routinely record patient smoking status, give 'very brief advice' to all smoking patients and inform the patient they are being referred to their local stop smoking service. This information will be recorded on the patient's notes, and be passed on to an administrator who will complete the electronic referral via the existing hospital system, ensuring that there is no need for double entry or duplication of patient details. The referral will then be sent to a 'referral bucket' which will sort patients by their postcode and send their details onto the appropriate stop smoking service. The stop smoking service will then act upon that referral either after receiving it directly into their 'Quit Manager' database or by an alert that will prompt the service to log into the referral bucket and retrieve their referrals. The number of trained staff will be monitored as the pilot progresses, and referral data will be generated on a monthly basis from October 2011 until the end of February 2012. The referrals will also be followed through to setting a quit date and the four-week follow-up point. A full evaluation will be completed by the end	

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		of March 2012, including recommendations for wider implementation.	
NCSCT Community Interest Company	4.3, Question 4	Linking community, primary, acute and obstetric care providers in smoking cessation is frequently challenging, despite being what could be deemed as a simple process. To ensure that these links are made, and that there is a seamless process, robust pathways need to be established, with systems in place to monitor and 'keep hold' of patients throughout the chain, both into acute services, and back out to community or primary care.	We cannot pre-empt the deliberations of the Committee responsible for developing the guidance and recommendations. These issues may be included in the final guidance, depending on the evidence available and there will however, be an opportunity for all stakeholders to comment on the guidance from April- June 2013.
NCSCT Community Interest Company	4.3, Question 5	The key learning points from the interim report of the Department of Health's 'Stop Smoking Interventions in Secondary Care' pilot were that: • Many sites struggled with the administrative elements of the pilot due to burdensome and difficult data collection and input, staffing issues and lack of support from the hospital. • The most expensive elements of the Department of Health's support package (pump-priming funding, SeCaD database and launch events) were not	Thank you.

Stakeholder Organisation	Section Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
		necessarily felt to be the most critical to success of the pilot; 'products' such as guidance, leaflets and clinical briefings rated very highly for usefulness • Ultimately, unless there is high level support, visible via funding for a dedicated hospital post, presence of a committed champion and dedication to thorough system change, these types of projects will be difficult to deliver successfully • There is a need to employ simple and clear data collection methods. • There is a need to start small and manageable and build in sufficient support mechanisms in order to help embed systematic and lasting change In addition to this, the NCSCT survey of those working in stop smoking support in secondary care found that just over half of respondents (51%) felt there were other levers in terms of engaging the acute trust in stop smoking support, examples of these are: *"Buy in of the agenda at the senior levels"* *"Clinical Champion to lead the programme, engage clinical staff and understand the specific culture of the organisation"* *"Compulsory training of staff in the hospital"* *"Easy referral pathways"*	

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		"Cost benefits to acute trusts" *"Engaging them in planning and development of the service, recognition and acknowledgement to staff"*	
NCSCT Community Interest Company	4.3, Question 5 (continued)	*"Full time member of staff working in the hospital with support of CQUIN targets"* *"Reducing the smokers on site, working towards a smokefree zone"* *"Using COPD strategy to work with the hospital"* *"Smoking being linked to the sustainability agenda within the trust"* The respondents were asked to state what elements they felt were needed to assist them in developing stop smoking support in secondary care effectively. The majority of respondents identified that the most important mechanisms were NRT being available on the hospital formulary (90.7%), training for staff (88.4%), senior management support (87.8%), Board level and PCT/LA support (83.7%) and a robust electronic referral system (62.8%).	Thank you. See above responses
NCSCT Community Interest Company	4.3, Question 6 & 7	There are a number of comments in response to these questions: • During a period of forced abstinence a patient will experience withdrawal symptoms from nicotine, such as irritability. To lessen these symptoms the patient	Thank you for all these detailed and helpful comments.

Stakeholder Organisation	Section Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
		should be offered NRT to ease their cravings. Identification of the patients smoking status needs to be carried out on admission and NRT offered as soon as possible so that the patient is more calm and comfortable, which in turn benefits the hospital staff. • A system needs to be established in the hospital for patients to receive NRT. Starting from the patient being offered NRT on admission if they are a smoker, to that information being recorded on the patient notes, and NRT reaching the patient via the pharmacy. The pharmacy need to stock appropriate products (i.e. the patch is often the only product stocked, and therefore there is not adequate patient choice, with anecdotal evidence from network meetings showing the inhalator being the most popular with hospital patients.), and NRT should be available for the patient upon discharge to hopefully facilitate continued abstinence.	
NCSCT Community Interest Company	4.3, Question 6 & 7 (continued)	In terms of effects of smoking on drug metabolism ▪ Smoking (mostly through the hydrocarbon agents in cigarette smoke) stimulates a liver enzyme responsible for metabolising some medicines in the body which mean that the metabolism of these medicines increases, resulting in lower blood levels of such medicines and hence a lower	Thank you for your suggestion. The scope has been amended to include a question about tobacco consumption, in addition to nicotine intake.

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		therapeutic effect. Some of these medications have a narrow therapeutic window, meaning too small a dose will be inaffective and too much will be toxic. If the doses of the medicine is titrated while the person is smoking, then when the person stops smoking the result could be toxicity or a significant increase in side effects from the medicine. Medicines affected in this way include (but are not restricted to) theophylline, insulin, paracetomol, propranolol, tamoxifen, verapamil, warfarin-R, as well as some medicines related to mental health, including antidepressants, antipsychotic medication, benzodiazepines, and opiates. ▪ Stopping smoking can therefore lead to the doses of some medications needing to be reduced by as much as 50% to achieve the same drug level and therapeutic effect. For medication with a narrow therapeutic range (i.e. clozapine), it is therefore recommended to reduce the daily drug dosage by 25% in week 1, accompanied by drug monitoring and further dose reductions as	The search strategy will be inclusive so if there are studies which refer to the implications for prescribing pharmacotherapies for the population groups outlined in the scope they will be considered for inclusion.

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		indicated ▪ This reduction in antipsychotic medication can be seen as an incentive, as patients would experience fewer often unpleasant side effects of their medication	We cannot pre-empt the deliberations of the committee. Evidence on this issue is likely to form the basis of a recommendation.
NCSCT Community Interest Company	4.3, Question 6 & 7 (continued)	• There are currently no guidelines with regard to reducing medication doses when cutting down (but not stopping) cigarette consumption and quit status monitored so doeses can be re • Many health care professionals are not aware of the effect of stopping smoking on drug levels in the blood and this is important to consider and to communicate • Communication with prescribers from primary and secondary care regarding reduction in doses of certain medications should occur prior to cessation and quit status monitored so doses can be reassessed should relapse occur	Thank you. See above responses
Newcastle upon Tyne Hospitals NHS Foundation Trust	General	We welcome the development of this guidance	Thank you for taking the time to read and comment on the draft scope.

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Newcastle upon Tyne Hospitals NHS Foundation Trust	General	We encourage the explicit recognition that every hospital admission is an opportunity for change	Thank you, noted.
Newcastle upon Tyne Hospitals NHS Foundation Trust	General	We suggest including explicit recommendations about quitting smoking before elective surgery, to address any concerns that might arise from clinicians with respect to a risk of rebound hypersecretion of mucus early after quitting.	Thank you, noted. We cannot pre-empt the deliberations of the Committee responsible for developing the guidance and recommendations. These issues may be included in the final guidance, depending on the evidence available and there will however, be an opportunity for all stakeholders to comment on the guidelines later in the process.
NHS Great Yarmouth and Waveney Stop Smoking Service	General	We welcome this guidance to develop secondary care Interventions in smoking cessation, but working within a hospital that uses paper systems to record events makes Evidence tracking difficult. Departments where systems are in place for referral for example pre assessment clinic work Well, but referrals from wards are erratic depending on who Is on duty. Electronic referral systems are a low priority	Thank you for taking the time to read and comment on the draft scope. Your comments are noted. The search strategy will be inclusive so if there are studies of the effectiveness of these approaches they will be considered for inclusion in the effectiveness and cost effectiveness reviews.

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		Here but would make referring easier. Nicotine withdrawal Management again does happen but very difficult to track. Overall the document highlights all the actions that need to Be addressed and a much needed piece of work	
Pennine Acute Hospitals NHS Trust	general	Currently the NHS stop smoking services support a 12 week quit programme - if this guidance supports a temporary quit, possibly over the duration of a pregnancy or a period in Hospital how will this be financially supported and will the figures be included in the DOH stats.	Thank you for taking the time to read and comment on the draft scope. NICE public health guidance does not set out which interventions should be financially supported. However, it does provide recommendations based on evidence of effective and cost-effectiveness. Guidance on specific messages will depend on the evidence available and the committee's deliberations of the evidence. We cannot pre-empt the outcome of this process.
Pennine Acute Hospitals NHS Trust	General	Home visits are quite time consuming but can be very successful as generally the client is more relaxed and	Thank you, noted.

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		open.	
Pennine Acute Hospitals NHS Trust	Background Section (d)	Please can you include midwives as part of their remit, as well as doctors and nurses.	Thank you. The scope, section 2d, has been amended to include midwives.
Pennine Acute Hospitals NHS Trust	The need for guidance Section (a)	It causes complications of pregnancy including low birth weight, which can lead to severe illness and development.	Thank you for your comments. The scope has been amended to provide examples of these pregnancy complications.
Pennine Acute Hospitals NHS Trust	4.2.1 b	Who do they anticipate will enforce no smoking in Hospital grounds?	Thank you for your comment. The guidance will be aimed at hospital trusts and other secondary care settings. Implementation decisions will be made locally.
Pfizer UK	4.1.1 and 4.2.1	Pfizer welcome that the guidance will focus on the links between smoking cessation and temporary abstinence interventions. It will be vitally important the guideline include information regarding patients who have undergone a period of temporary abstinence and are subsequently willing to undergo a smoking cessation attempt. Smoking cessation or temporary abstinence in secondary care offers an excellent 'teachable moment' for smokers. The literature supports the notion that	Thank you for taking the time to read and comment on the draft scope. Your comments are noted. We cannot pre-empt the deliberations of the Committee responsible for developing the guidance and recommendations. The issues that you raise are within the

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		patients are at a high level of motivation to undergo a quit attempt after a period of temporary abstinence. Temporary abstinence owing to hospitalisation can increase the motivation to quit definitely.[1] It will be important for this guideline to cover interventions offered at discharge so that potentially motivated quitters are not without support and access to appropriate treatment, including pharmacotherapy, as they transition out of the secondary care environment. 1. Rigotti N, Munafo M et al. Interventions for smoking cessation in hospitalised patients. Cochrane Database System Review. Issue 4. 2003	scope may be included in the draft guidance, depending on the evidence available. Please note, there will be an opportunity for all stakeholders to comment on the draft guidance from April- June 2013.
Pfizer UK	4.3, question 4	Pfizer strongly support the intention to improve the transition from the acute setting to community or hospital-based stop-smoking services. Pfizer highlight the importance of smoking cessation training to all members of the secondary care team, and the alignment of patient pathways to ensure the continuity of a smoking cessation attempt from secondary care into primary care. This will ensure that smoking cessation treatment offered to patients in the secondary care setting isn't limited by prescribers' concerns that treatment may cease upon discharge from the secondary care setting.	Thank you, noted. Thank you. These are important considerations. Please see our response above.

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Pfizer UK	4.3, question 9	It will important that any recommendation of temporary abstinence is not misinterpreted by some smokers as permission to continue smoking after discharge. Pfizer again stress that the guideline should highlight the need for continued and integrated access to smoking cessation services and appropriate pharmacotherapy upon discharge from the secondary care setting.	Thank you, noted. Please see response above.

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Positively UK	General	There are high rates of smoking amongst HIV positive people: this in addition to being HIV positive puts this cohort of patients at higher risk of developing CVD, including type 2 diabetes, than much of the general population. HIV treatment centres in acute settings provide an ideal setting to provide information and support to HIV patients to quit. (annual CVD risks assessments should be part of treatment and care they provide: these provide an ideal opportunity to promote smoking cessation) Traditionally HIV treatment and prevention services have tended not to promote smoking cessation. Whilst the funding towards HIV prevention is unlikely to allow for smoking cessation work however this guidance will facilitate and reinforce the need for HIV treatment centres to address smoking cessation amongst their smoking patients. Stronger links could be made between HIV treatment centres and obstetric services (as they will be working with HIV positive pregnant women) with smoking cessation providers and HIV community support groups to ensure that the stigma associated with HIV does not prevent HIV positive patients who wish to quit smoking from accessing smoking cessation support.	Thank you for taking the time to read and comment on the draft scope. We cannot pre-empt the decisions of the Committee that will develop the guidance, but it will be looking at a range of evidence and will consider recommendations for smoking cessation advice integrated within care pathways.
Positively UK		A way to support implementation of Smokefree strategies and interventions in acute settings and	Thank you for these suggestions. If there is

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		obstetric health settings is to get buy-in and involvement of staff (restricting staff smoking breaks alone could cause resentment) therefore consideration should be given to: • offering on-site smoking cessation support/ services • incentives to encourage staff to stop smoking • educating staff providing HIV treatment and care in the specific risks associated with being an HIV positive smoker • building strong links with HIV community advocate projects that provide can provider peer mentoring and other support to encourage HIV patients to stop smoking • provide Level 1 & 2 smoking cessation training for all staff working with patients and the public to widen access to smoking cessation support • consider development of in-house Health Champions (accredited by RSPH) to provide brief advice and signpost other staff and patients to smoking cessation services • consider development of Health Trainer role amongst paid/unpaid staff cohort to support other staff and patients to stop smoking (the latter three are professional development incentives)	evidence of such approaches, these will be considered by the Committee that develops the guidance.

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Positively UK	4.1 Groups covered	It needs to be clearer that the Smokefree guidance will apply in the home or other enclosed non-clinical setting or premise where a staff member may be visiting a patient, this may need to include community group settings such as third sector HIV support projects	Thank you for your comment. These settings will be important to the guidance. However, these settings are covered in section 4.2.1; this section includes reference to smoke-free strategies in community settings and private residences.
Positively UK		It needs to clear if this will apply to all people working acute and obstetric settings including volunteers, contract staff and staff working in commercial franchises e.g. WH Smiths or Costa Coffee etc in addition to the salaried NHS employees.	Thank you for the suggestion. The scope has been amended to include support staff, volunteers, agency/locum staff and those employed by contractors.
Positively UK		Attitudes to smoking and tobacco use vary across ethnic groups and cultures: some people smoke shisha or chew tobacco rather than pipes, cigars and cigarettes and unaware of the harm this causes. There need to be consistent messages within healthcare settings and from staff about the harm caused by all tobacco use, even though the focus of this guidance is on smoking cessation. Likewise there may need to be specific consideration of the needs for gay men: gay men have higher levels of smoking cessation than straight men and therefore HIV	Thank you, noted. When developing the guidance the committee will take into account any cultural or equity issues that may affect the uptake of interventions. In addition where it is appropriate fieldwork may be commissioned to test feasibility of the recommendations in practice.

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		positive gay men are at a high risk of developing a range of health problems.	You may be interested in other NICE guidance in development; it will consider interventions to reduce the use of smokeless tobacco products used by some ethnic groups and cultures. (see http://guidance.nice.org.uk/PHG/Wave23/20).

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Positively UK	4.3 Key questions	Perhaps questions to consider might include: - How do we motivate patients with acute health problems to stop smoking when the treatment of their health condition (e.g. their HIV) is their main concern?	Thank you. As far as the evidence allows the review will address these detailed questions as they will inform the process of developing recommendations.
Primary Care Cardiovascular Society (PCCS)	General	Although this scope covers acute and obstetric settings strong an emphasis on promoting good networks, effective patient pathways and collaborative working with primary care stop smoking provision (e.g. GPs, pharmacy, community services etc) would be beneficial particularly for acute cardiac healthcare departments and obstetrics (midwifery services). This would then facilitate consistency in smoking cessation messages across all NHS commissioned services and have the potential to ensure there is seamless access to stop smoking support for patients on discharge, who are outpatients or using maternity services. It may enable patients who smoke to be better informed of smoking restrictions and what measures are in place to support them not to smoke in acute settings when and if they need to access acute and obstetric services. Provision of joint smoking cessation training for staff from mental health, acute and primary care settings on	Thank you for your comments. We cannot pre-empt the deliberations of the Committee responsible for developing the guidance and recommendations. There will be an opportunity for all stakeholders to comment on the draft guidance when it is issued for consultation in April - June 2013

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		encouraging and supporting patients to stop smoking may promote consistency in messages for patients. It would help each sector understand the challenges the others face to promote smoking cessation to their patients to enable better management of smoking cessation for patients who may be accessing all three services simultaneously. Departments and services that treat patients with conditions that are strongly linked to smoking such as Cardiac Rehab may be able to inform and encourage other departments in how best to address smoking cessation amongst patients. Encourage Acute trusts to be part of their local Smokefree/ tobacco control programmes. Membership of local cardiac networks (where they exist) also has the potential to the improve knowledge and opportunities to promote smoking cessation within acute settings: cardiac members from the acute trusts have the potential to be smoking cessation champions and experts on whom their colleagues can seek support and advice on how to ensure this guidance is implemented.	

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Primary Care Cardiovascular Society (PCCS)	4.1 Groups covered	It needs to be clearer that the Smokefree guidance will apply in the home or other enclosed non-clinical setting or premise where an NHS (or NHS contracted) staff member may be visiting a patient	Thank you for your comment. These settings will be important to the guidance. They are covered in section 4.2.1; this section includes reference to smokefree strategies in community settings and private residences.
Primary Care Cardiovascular Society (PCCS)		It needs to clear if this will apply to all people working acute and obstetric settings including volunteers, contract staff, and staff working in commercial franchises e.g. WH Smiths or Costa Coffee etc in addition to the salaried NHS employees.	Thank you for the suggestion. The scope has been amended to include support staff, volunteers, agency/locum staff and those employed by contractors.
Primary Care Cardiovascular Society (PCCS)		Attitudes to smoking and tobacco use vary across ethnic groups and cultures: some people smoke shisha or chew tobacco rather than pipes, cigars and cigarettes and unaware of the harm this causes. There need to be consistent messages within healthcare settings and from staff about the harm caused by all tobacco use, even though the focus of this guidance is on smoking cessation.	Thank you, noted. When developing the guidance the committee will take into account any cultural or equity issues that may affect the uptake of interventions. In addition where it is appropriate fieldwork may be commissioned to test feasibility of the recommendations in practice.. You may be interested in other

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			NICE guidance in development; it will consider interventions to reduce the use of smokeless tobacco products used by some ethnic groups. (see http://guidance.nice.org.uk/PHG/Wave23/20).

Public Health Programme Guidance

Smoking cessation in secondary care –acute and obstetric services- Consultation on Draft Scope Stakeholder Comments Table 1st -29th September 2011

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Stakeholder Organisation	Section Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Primary Care Cardiovascular Society (PCCS)	4.2 Activities 4.2.1 b)	A way to support implementation of Smokefree strategies and interventions in acute settings and obstetric health settings is to get buy-in and involvement of staff (restricting staff smoking breaks alone could cause resentment) therefore consideration should be given to: • offering on-site smoking cessation support/ services • incentives to encourage staff to stop smoking • provide Level 1 & 2 smoking cessation training for all staff working with patients and the public to widen access to smoking cessation support • consider development of in-house Health Champions (accredited by RSPH) to provide brief advice and signpost other staff and patients to smoking cessation services • consider development of Health Trainer role amongst paid/unpaid staff cohort to support other staff and patients to stop smoking (the latter three are professional development incentives)	Thank you for these suggestions. The scope sets out the overarching questions to be covered in the guidance and the evidence reviews. Each overarching question is underpinned by a set of detailed research questions The evidence reviews will address these detailed questions to inform the development of the recommendations.
Primary Care Cardiovascular Society (PCCS)	4.3 Key Questions and outcomes	Perhaps questions to consider might include: - How do we motivate patients with acute health problems problems to stop smoking when the treatment and management of their health condition(s) is likely to be their main concern?	Thank you for your comment. If available, this information will be retrieved as part of the evidence reviews within the framework of questions already

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			outlined. The list provides some overarching questions from which the detailed research questions and outcomes to be considered will be derived. It is not intended to be exhaustive.
Royal College of Midwives	General	The language is confusing in the title - these services should more appropriately be named ' maternity' rather than ' obstetric '.	Thank you for taking the time to read and comment on the draft scope. The scope has been amended and 'maternity services' now replaces 'obstetric services' throughout the document.
Royal College of Midwives	General	The involvement of stakeholder groups should be more explicitly inclusive and involve groups that interact at practical and grass root levels such as The Race Foundation.	We aim to involve and recruit relevant stakeholders through our stakeholder consultation processes. National, public, community, patient, carer and voluntary organisations are welcomed to register as stakeholders. Further details can be found here: http://www.nice.org.uk/ourguidance/niceguidancebytype/publichealthguidance/stakeholderregistration/ph

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Royal College of Midwives	2 b	As above, these should be described as 'maternity' care settings instead of obstetric. This applies all the way through the document.	Noted, thank you. See above response.
Royal College of Midwives	2 b	It is important to include recommendations that address the interface between primary and secondary.	Thank you, noted. We cannot pre-empt the deliberations of the committee but the guidance will include recommendations be mindful of integrating smoking cessation information, advice and support within care pathways. See 4.2.1a) in the scope
Royal College of Midwives	2 c	There are relevant documents that are missing here that are important to the context of deprivation and equity - the recent reports by Louise Casey (Review into the Needs of Families Bereaved by Homicide) , Frank Field (The Foundation Years), and Graham Allen (Early Intervention)	Thank you. We agree that these are important reports; however, section 2c of the scope document is reserved for reference to directly related policy documents.
Royal College of Midwives	2 d	The list of professionals here must include midwives. They are very active in this area, and by excluding them it implies the guideline may not be relevant to them.	Thank you. The scope, section 2d, has been amended to include midwives.

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Royal College of Midwives	4.1.1	'People living in the same household' - it is important to name 'children' here as they suffer disproportionately from the effects of second hand smoke.	Thank you for your comment. The groups listed in section 4.1.1 are people who smoke. The purpose of this section of the scope is to set out what groups will be covered by any activities or interventions. People that benefit from any interventions may include the children of the groups listed in section 4.1.1.
Royal College of Midwives	4.1.2	We do not think it is appropriate to exclude 'people who have quit smoking for at least 12 months', as relapse is so common.	Thank you for your comments. Your concerns are noted. We have excluded long term ex-smokers of more than 12 months as there is good evidence to suggest that permanent cessation is high amongst this group. There are also practical implications of providing continued support for long term ex-smokers.
Royal College of Midwives	4.2.1	We are pleased to see the focus on integration of information, advice and support on smoking cessation within care pathways.	Thank you.
Royal College of	4.2.2	It is not clear why 'programmes or interventions aimed at	Thank you. We appreciate the

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Midwives		preventing the uptake of tobacco use' are not going to be included here.	importance of interventions aimed at preventing the uptake of tobacco. However it is important to produce a scope that is achievable within the available time and resources. Future guidance for secondary care settings may cover this topic.
Royal College of Midwives	4.3 Question 7	Expected outcomes - it would be more appropriate to define a successful long term quit attempt, as longer than 12 months	Thank you. We have defined a long term quit attempt as at least 12 months.
Royal College of Midwives	4.3 Question 7	The successful outcome of 'increased referrals' - should clearly align with quitting attempts	Thank you. We have asked two questions, one about quit attempts and another about referrals to acknowledge that they may not be recorded as one combined outcome.
Royal College of Midwives	4.3 Question 7	'health improvement' - ' improved outcomes for children' should be a primary outcome here	Thank you. We have amended the scope to emphasise outcomes for children.
Royal College of Nursing	general	The Royal College of Nursing welcomes proposals to develop this guidance. .	Thank you.
Royal College of Nursing	general	The draft scope covers the main areas appears to be very comprehensive.	Thank you.

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		The questions are not just exploring at individual patients, but also community support when they are discharged, this is welcomed.	
Royal College of Paediatrics and Child Health	General	Parents and other visitors to neonatal units and paediatric wards and clinics should be specifically added. The document is clear about the risks to children then completely omits these settings.	Thank you for taking the time to read and comment on the draft scope. Parents and other visitors to secondary care settings are included under the scope of the guidance in section 4.1.1.
Royal College of Paediatrics and Child Health	General	The scope appears appropriate.	Thank you.
Royal College of Paediatrics and Child Health	3(e)	The emphasis on smoking in teenage pregnancy is welcome.	Thank you.
Royal College of Paediatrics and Child Health	4.1.1	The document needs to make it explicit whether it includes children and young people within its remit.	Thank you for your comment. The scope will cover people of all ages. The scope has been amended to make this clear.
Royal College of Paediatrics and Child Health	4.3	If children and young people are to be included, then guidance for this age group will need to be considered separately, as the evidence base is very different - see subsidiary question 1b. *Ref.* *Smoking cessation services for young people. Gill*	Thank you for these suggestions. We cannot pre-empt the decisions of the committee that will develop the guidance, but they will be looking at a range of

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		Grimshaw, Alan Stanton BMJ 2008;337:a1394, doi: 10.1136/bmj:a1394 *"Tobacco cessation interventions for young people" Gill Grimshaw, Alan Stanton, Cochrane database of systematic reviews, 2009*	evidence and will consider the need for recommendations targeting different groups, for example based on age. We will pass on this information to the team undertaking the evidence review.
Royal College of Paediatrics and Child Health	Expected outcomes	These need to stress that we are looking for 6 or 12 months continuous cessation, not (as is sometimes reported) point prevalence of cessation at these times. In other words, long term cessation should not be implied if someone is not smoking 12 months after a quit attempt, but smoked for 11 of those 12 months. *Ref:* *West R, Hajek P, Stead L, Stapleton J. Outcome criteria in smoking cessation trials: proposal for a common standard. Addiction 2005;100:299-303.*	Thank you for the suggestion. The scope has been amended; it now refers to continuous abstinence.
The Roy Castle Lung Cancer Foundation	General	While we welcome this opportunity to focus on obstetric health services the majority of patients within acute care will not fall into this category. Each hospital is like a small town and as such presents the same challenges as its local community. Choosing to focus on such a specific area is likely to result in significant gaps and is a lost opportunity to develop a seamless service between	Thank you for taking the time to read and comment on the draft scope. The guidance will cover acute and obstetric care settings. As such it is very broad in its scope. It also aims to address

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		hospital and primary care.	collaboration between how hospital and primary care providers.
UK Clinical Pharmacy Association (UKCPA) Respiratory Group	General	UKCPA welcome this scoping document; we have no comments to make at this stage.	Thank you for taking the time to read and comment on the draft scope.