

NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

Health and social care directorate

Quality standards and indicators

Briefing paper

Quality standard topic: Smoking cessation: supporting people to stop smoking.

Output: Prioritised quality improvement areas for development.

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1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for a NICE quality standard on smoking cessation: supporting people to stop smoking.

It provides the Committee with a basis for discussion when prioritising quality improvement areas for developing the draft quality standard statements and measures. The draft quality standard will be the subject of public consultation.

Key development source(s)

Unless otherwise stated, the key development sources referenced in this briefing paper are as follows:

- [Quitting smoking in pregnancy and following childbirth](#). NICE public health guidance 26 (2010).
- [Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities](#). NICE public health guidance 10 (2008).
- [Reducing the rate of premature deaths from cardiovascular disease and other smoking-related diseases: finding and supporting those most at risk and improving access to services](#). NICE public health guidance 15 (2008).
- [Varenicline for smoking cessation](#). NICE technology appraisal 123 (2007).
- [Brief interventions and referral for smoking cessation](#). NICE public health guidance 1 (2006).

Where relevant, recommendations from the key development sources are presented alongside each of the suggested areas for quality improvement within the main body of the report.

2 Overview

2.1 Focus of quality standard

The focus of this quality standard is NHS provided or commissioned support for people to stop smoking.

2.2 Smoking overview

The 2011 Department of Health (DH) policy document “Healthy lives healthy people – A tobacco control plan for England”¹ states that smoking is the primary cause of preventable morbidity and premature death, accounting for 81,400 deaths in England in 2009. In England, deaths from smoking are more numerous than the next six most common causes of preventable death combined (i.e. drug use, road accidents, other accidents and falls, preventable diabetes, suicide and alcohol abuse)¹.

It also explains that smoking rates are much higher in some social groups, including those with the lowest incomes. These groups suffer the highest burden of smoking-related illness and death. Smoking is the single biggest cause of inequalities in death rates between the richest and poorest in our communities¹.

Figures taken from the document estimate that smoking-related illnesses cost the NHS £2.7 billion in 2006/07, or over £50 million every week. In 2008/09, some 463,000 hospital admissions in England among adults aged 35 and over were attributable to smoking, or some 5 per cent of all hospital admissions for this age group. Clearly, the costs of tobacco use are much greater than just costs to the NHS, and the overall economic burden of tobacco use to society is estimated at £13.74 billion a year¹.

2.3 Incidence and prevalence

While rates of smoking have continued to decline over the past decades, around 21 per cent of adults in England still smoke. Smoking prevalence has fallen little since 2007¹.

It is estimated that each year in England around 340,000 children under the age of 16 who have never smoked before try smoking cigarettes. In 2011 the prevalence of male smokers aged 11-15 was 4%, for females 5%².

¹ Department of Health (2011a) Healthy Lives, Healthy People: A Tobacco Control Plan for England.

² Action on Smoking and Health (2012) ‘Young people and smoking factsheet’.

2.4 *Management*

“Healthy lives healthy people – A tobacco control plan for England” states that there is clear evidence that the most effective tobacco control strategies involve taking a multi-faceted and comprehensive approach at both national and local level¹.

It recognises that while nicotine keeps tobacco users physically dependent, there are a wide range of social and behavioural factors that encourage young people to take up smoking and that make it harder for tobacco users to quit¹.

The document states that the Government’s approach to improving public health includes tackling the wider social determinants of health and it aims to build people’s self-esteem, confidence and resilience. The Government is also attempting to make tobacco less desirable, less acceptable and less accessible¹.

NICE has published several public health guidance documents which describe the support which should be available for people to stop smoking. PH1³ describes brief interventions (where a brief intervention is defined as opportunistic advice, discussion, negotiation or encouragement for smokers) and referral to smoking cessation services from primary care and other settings, including secondary care. This guidance states that people should be asked whether they smoke (and advised to stop unless there are exceptional circumstances). Their commitment to quitting should be assessed, and they may then be offered a referral to an intensive support service e.g. NHS Stop Smoking Services (SSS). If this is not accepted then they may be offered pharmacotherapy.

PH10⁴ concerns smoking cessation services in primary care, pharmacies, local authorities and workplaces. Although it is for all people who smoke, it is written particularly for manual working groups, pregnant women and hard to reach communities. This describes the interventions which should be available, including:

- Individual behavioural counselling – scheduled face-to-face meetings between someone who smokes and a counsellor trained in smoking cessation. Typically, it involves weekly sessions over a period of at least 4 weeks after the quit date and is normally combined with pharmacotherapy
- Group behaviour therapy – scheduled meetings where people who smoke receive information, advice and encouragement and some form of behavioural intervention (for example, cognitive behavioural therapy). This therapy is offered weekly for at least the first 4 weeks of a quit attempt (that is, for 4 weeks following the quit date). It is normally combined with pharmacotherapy.

³ Brief interventions and referral for smoking cessation in primary care and other settings

⁴ Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities

- Pharmacotherapy – these are drugs which are typically prescribed alongside advice, encouragement and support, or referral to a smoking cessation service. There are three types of pharmacotherapy prescribed:
 - Nicotine replacement therapy (NRT) (which reduces withdrawal symptoms by getting nicotine into the body)
 - Bupropion – reduces cravings, withdrawal symptoms and suppresses the part of the brain which gives smokers a ‘nicotine buzz’
 - Varenicline reduces cravings, withdrawal symptoms and satisfaction received from smoking (there is also a separate technology appraisal (TA123) which recommends the use of this drug)
- Or a combination of varying treatments including those described above and others e.g. self-help materials.

PH15⁵ outlines recommendations in improving access to services for those with smoking-related diseases.

PH26⁶ relates to stopping smoking during pregnancy and following childbirth. It includes identification and referral, and interventions (including cognitive behaviour therapy, motivational interviewing, structured self-help and support from NHS Stop Smoking Services). It also contains some recommendations on nicotine replacement therapy and pharmacological support, stating that the evidence on effectiveness and risks to the baby are unclear, therefore the risks and benefits should be discussed. There are also specific recommendations for women who are disadvantaged, and recommendations for those whose partners smoke.

NICE has published several other guidance documents which concern support in a non-NHS setting and hence are outside of the scope of this QS. These include PH23 (school-based interventions to prevent the uptake of smoking among children), PH14 (preventing the uptake of smoking by children and young people), and PH5 (workplace interventions to promote smoking cessation).

See appendix 1 for the key priorities for implementation recommendations from Public Health guidance PH10.

2.5 National outcome frameworks

The table below shows the indicators from the frameworks that the quality standard could contribute to:

⁵ Reducing the rate of premature deaths from cardiovascular disease and other smoking-related diseases: finding and supporting those most at risk and improving access to services

⁶ How to stop smoking in pregnancy and following childbirth

NHS outcomes framework 2013–14

<p>Domain 1: Preventing people from dying prematurely.</p>	<p>Overarching indicators</p> <p>1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare</p> <p>1b Life expectancy at 75 i males ii females</p> <p>Improvement areas</p> <p><i>Reducing premature mortality from the major causes of death</i></p> <p>1.1 Under 75 mortality rate from cardiovascular disease</p> <p>1.2 Under 75 mortality rate from respiratory disease</p> <p><i>Cancer</i></p> <p>1.4.i One-and ii Five-year survival from all cancers</p> <p>iii One-and iv Five-year survival from breast, lung and colorectal cancer</p> <p><i>Reducing premature death in people with serious mental illness</i></p> <p>1.5 Excess under 75 mortality rate in adults with serious mental illness</p> <p><i>Reducing deaths in babies and young children</i></p> <p>1.6.i Infant mortality ii Neonatal mortality and stillbirths</p> <p><i>Reducing premature death in people with learning disabilities</i></p> <p>1.7 Excess under 60 mortality rate in adults with a learning disability</p>
<p>Domain 2: Enhancing quality of life for people with long-term conditions</p>	<p>Overarching indicator</p> <p>2 Health-related quality of life for people with long-term conditions</p> <p>Improvement areas</p> <p>Ensuring people feel supported to manage their condition</p> <p><i>Improving functional ability in people with long-term conditions</i></p> <p>2.2 Employment of people with long-term conditions</p> <p><i>Reducing time spent in hospital by people with long-term conditions</i></p> <p>2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)</p> <p>2.3 ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s</p> <p><i>Enhancing quality of life for carers</i></p>

	<p>2.4 Health-related quality of life for carers Enhancing quality of life for people with mental illness</p> <p>2.5 Employment of people with mental illness</p>
<p>Domain 3: Helping people to recover from episodes of ill health or following injury</p>	<p>Overarching indicators</p> <p>3a Emergency admissions for acute conditions that should not usually require hospital admission</p> <p>3b Emergency readmissions within 30 days of discharge from hospital</p> <p>Improvement areas</p> <p><i>Improving outcomes from planned procedures</i></p> <p>3.1 Patient Reported Outcomes Measures (PROMs) for elective procedures</p> <p>3.1i Hip replacement</p> <p>3.1ii Knee replacement</p> <p>3.1iii Groin hernia</p> <p>3.1iv Varicose veins</p> <p><i>Preventing lower respiratory tract infections (LRTI) in children from becoming serious</i></p> <p>3.2 Emergency admissions for children with LRTI</p> <p><i>Improving recovery from injuries and trauma</i></p> <p>3.3 Proportion of people who recover from major trauma</p> <p><i>Improving recovery from stroke</i></p> <p>3.4 Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months</p> <p><i>Improving recovery from fragility fractures</i></p> <p>3.5 The proportion of patients recovering to their previous levels of mobility / walking ability at</p> <p>3.5i 30 and</p> <p>3.5ii 120 days</p> <p><i>Helping older people to recover their independence after illness or injury</i></p> <p>3.6 Proportion of older people (65 and over) who were</p> <p>3.6i still at home 91 days after discharge into rehabilitation</p> <p>3.6ii offered rehabilitation following discharge from acute or community hospital</p>
<p>Public Health Outcomes Framework 2013–14</p>	

<p>Domain 2: Health improvement</p>	<p>Objective <i>People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities</i></p> <p>2.1 Low birth weight of term babies 2.3 Smoking status at time of delivery 2.9 Smoking prevalence – 15 year olds (Placeholder) 2.14 Smoking prevalence – adult (over 18s)</p>
<p>Domain 4: Healthcare public health and preventing premature mortality</p>	<p>Objective <i>Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities</i></p> <p>4.3 Mortality from causes considered preventable 4.4 Mortality from all cardiovascular diseases (including heart disease and stroke) 4.5 Mortality from cancer 4.7 Mortality from respiratory diseases 4.9 Excess under 75 mortality in adults with serious mental illness (Placeholder) 4.12 Preventable sight loss 4.13 Health-related quality of life for older people (Placeholder)</p>
<p>Social Care Outcomes Framework 2013–14</p>	
<p>Domain 1: Enhancing quality of life for people with care and support needs</p>	<p>Outcome measures <i>Carers can balance their caring roles and maintain their desired quality of life</i></p> <p>1D Carer-reported quality of life <i>People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation</i></p> <p>1E Proportion of adults with a learning disability in paid employment 1F Proportion of adults in contact with secondary mental health services in paid employment</p>
<p>Domain 2: Delaying and reducing the need for care and support</p>	<p>Outcome measures <i>Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs.</i></p> <p><i>Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive</i></p>

	<p><i>services.</i></p> <p>2B. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services</p>
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3 Summary of suggestions

3.1 Responses

In total twelve stakeholders submitted suggestions for quality improvement as part of the 2-week engagement exercise (09/11/12 – 23/11/12).

Table 1 Summary of suggested quality improvement areas

Stakeholders were asked to suggest up to 5 areas for quality improvement. These have been merged and summarised in the table below for further consideration by the Committee.

The full detail of the suggestions is provided in appendix 2

Suggested key improvement areas	Stakeholder
<p>Smoking in pregnancy</p> <ul style="list-style-type: none"> Offer interventions to pregnant women (no particular interventions specified however the focus should be on women from disadvantaged backgrounds). 	<ul style="list-style-type: none"> National Childbirth Trust
<p>Identification and referral</p> <ul style="list-style-type: none"> Routine and systematic identification and referral of smokers (which may form part of brief interventions (see below)) 	<ul style="list-style-type: none"> National Centre for smoking Cessation and Training

Suggested key improvement areas	Stakeholder
<p>Brief interventions</p> <ul style="list-style-type: none"> • Offering a brief intervention or some component of a brief intervention to people who smoke, including <ul style="list-style-type: none"> ○ advice, ○ help to quit, ○ encouragement to attend stop smoking services. • This may be <ul style="list-style-type: none"> ○ in specific settings (including secondary care and ophthalmology) ○ for specific sub-groups (prisoners, people with respiratory conditions (with asthma and COPD specifically mentioned)). 	<ul style="list-style-type: none"> • DH Respiratory Programme • NHS Central Lancashire • Primary Care Respiratory Society UK • National Centre for Smoking Cessation and Training • The Royal College of Ophthalmologists
<p>Behavioural change support</p> <ul style="list-style-type: none"> • Behavioural change support combined with pharmacotherapy 	<ul style="list-style-type: none"> • Royal College of Physicians • UK Centre for Tobacco Control Studies • National Centre for Smoking Cessation and Training
<p>Pharmacotherapy</p> <ul style="list-style-type: none"> • Offer nicotine replacement therapy, varenicline or bupropion, as appropriate, to people who are planning to stop smoking in primary and secondary care • Pharmacotherapy combined with behavioural change support. 	<ul style="list-style-type: none"> • Royal College of Physicians • UK Centre for Tobacco Control Studies • National Centre for Smoking Cessation and Training
<p>Holistic lifestyle advice</p> <ul style="list-style-type: none"> • Weight management • Integration of lifestyle services (smoking, alcohol and weight management) 	<ul style="list-style-type: none"> • NHS Central Lancashire • Dietitians in Obesity Management UK • The British Dietetic Association
<p>Measurement and audit</p> <ul style="list-style-type: none"> • Measure/capture/have an idea of the number of smokers (including smokers who are pregnant and smokers with respiratory conditions, in settings including primary and emergency/unscheduled care) • Audit as a method to capture outcomes. 	<ul style="list-style-type: none"> • Department of Health Respiratory Programme • Royal College of Physicians • UK Centre for Tobacco Control Studies • Primary Care Respiratory Society UK • National Centre for Smoking Cessation and Training • Pfizer Limited

Suggested key improvement areas	Stakeholder
Smoking cessation service recommendation <ul style="list-style-type: none"> Availability of stop smoking services at evenings and weekends 	<ul style="list-style-type: none"> Primary Care Respiratory Society UK

Table 2 Stakeholder details (abbreviations)

The details of stakeholder organisations who submitted suggestions are provided in the table below.

Abbreviation	Full name
BDA	The British Dietetic Association
DH Respiratory Programme	Department of Health Respiratory Programme
domUK	Dietitians in Obesity Management UK
NCSCT	The National Centre for Smoking Cessation and Training
NCT	The National Childbirth Trust
NHS Central Lancashire	National Health Service Central Lancashire (Central Lancashire Primary Care Trust)
Pfizer	Pfizer
PCRSUK	Primary Care Respiratory Society UK
RCN	The Royal College of Nursing
RCP	The Royal College of Physicians
RCOphth	The Royal College of Ophthalmologists
UKCTCS	UK Centre for Tobacco Control Studies

4 Suggested improvement area: Smoking and pregnancy

4.1 Summary of suggestions

One stakeholder felt that there should be a statement on smoking and pregnancy but did not provide specific detail of what this should cover (however said the focus should be particularly on those from disadvantaged areas).

NICE technical note: As no specific intervention is suggested, it is recommended that pregnancy is considered for each individual area of care.

4.2 Selected recommendations from development source

PH26 concerns smoking during pregnancy and following childbirth. PH10 also contains recommendations for women who are pregnant. As no specific intervention was suggested by the stakeholder, and as the areas of care are broadly similar for the general population and for pregnant women, the recommendations are not reproduced. Many of the recommendations are contained underneath other areas of care in this document.

4.3 Current UK practice

In quarter 1 2012/13, the percentage of mothers smoking at delivery was 12.7%, lower than the 2011/12 outturn (13.2%), 2010/11 outturn (13.5%) and 2009/10 outturn (14.1%) (Health and Social Care Information Centre, 2012b)⁷.

These rates suggest there is room for quality improvement for smoking cessation interventions for women who are pregnant.

⁷ Health and Social Care Information Centre (2012b) 'Statistics on women's smoking status at time of delivery: England, Quarter 1, 2012/13'.

5 Suggested improvement area: identification and referral

5.1 *Summary of suggestions*

This area of care was suggested by one stakeholder, who felt that smokers frequently attempted to quit alone via less effective methods such as independent cessation or over the counter pharmacotherapy, rather than seeking professional help.

NICE technical note: The process of identification, brief intervention and referral can be fluid and interdependent, therefore this area of care should be considered alongside the next area of care (brief interventions).

5.2 *Selected recommendations from development source*

Recommendations from the development sources relating to the suggested improvement areas have been provisionally selected and are presented below to inform the Committee in their discussions.

[Brief interventions and] referral for smoking cessation in primary care and other settings

PH1

Recommendation 1

Everyone who smokes should be advised to quit, unless there are exceptional circumstances. People who are not ready to quit should be asked to consider the possibility and encouraged to seek help in the future. If an individual who smokes presents with a smoking-related disease, the cessation advice may be linked to their medical condition.

Recommendation 2

People who smoke should be asked how interested they are in quitting. Advice to stop smoking should be sensitive to the individual's preferences, needs and circumstances: there is no evidence that the 'stages of change' model is more effective than any other approach.

Recommendation 3

GPs should take the opportunity to advise all patients who smoke to quit when they attend a consultation. Those who want to stop should be offered a referral to an intensive support service (for example, NHS Stop Smoking Services). If they are

unwilling or unable to accept this referral they should be offered pharmacotherapy in line with NICE technology appraisal guidance no. 39 and additional support. The smoking status of those who are not ready to stop should be recorded and reviewed with the individual once a year, where possible.

Recommendation 4

Nurses in primary and community care should advise everyone who smokes to stop and refer them to an intensive support service (for example, NHS Stop Smoking Services). If they are unwilling or unable to accept this referral they should be offered pharmacotherapy by practitioners with suitable training, in line with NICE technology appraisal guidance no. 39, and additional support. Nurses who are trained NHS stop smoking counsellors may 'refer' to themselves where appropriate. The smoking status of those who are not ready to stop should be recorded and reviewed with the individual once a year, where possible.

Recommendation 5

All other health professionals, such as hospital clinicians, pharmacists and dentists, should refer people who smoke to an intensive support service (for example, NHS Stop Smoking Services). If the individual is unwilling or unable to accept this referral, practitioners with suitable training should offer a prescription of pharmacotherapy in line with NICE technology appraisal guidance no. 39, and additional support. Those who are trained NHS stop smoking counsellors may 'refer' to themselves. Where possible, the smoking status of those who are not ready to stop should be recorded in clinical records and reviewed with the individual once a year, where possible.

Recommendation 6

Community workers should refer people who smoke to an intensive support service (for example, NHS Stop Smoking Services). Those who are trained NHS stop smoking counsellors may 'refer' to themselves.

Recommendation 9

Monitoring systems should be set up to ensure health professionals have access to information on the current smoking status of their patients. This should include information on: a) the most recent occasion on which advice to stop was given, b) the nature of advice offered and c) the response to that advice.

Identification

PH10

Recommendation 6 (bullet point 2)

Healthcare professionals should identify and record the smoking and/or tobacco use status of all their patients. Those who use tobacco should be:

- reminded at every suitable opportunity of the health benefits of stopping
- offered brief advice and, if they want to stop using tobacco, referred to the local NHS Stop Smoking Service. If patients do not wish to attend the service, they should be offered brief advice and support to help them quit, and pharmacotherapy as appropriate.

Recommendations for stopping smoking in pregnancy and following childbirth – Identifying pregnant women who smoke and referring them to NHS Stop Smoking Services – action for midwives

(Who should take action – Midwives (at first maternity booking and subsequent appointments))

PH26

Recommendation 1

- Assess the woman's exposure to tobacco smoke through discussion and use of a CO test. Explain that the CO test will allow her to see a physical measure of her smoking and her exposure to other people's smoking. Ask her if she or anyone else in her household smokes. To help interpret the CO reading, establish whether she is a light or infrequent smoker. Other factors to consider include the time since she last smoked and the number of cigarettes smoked (and when) on the test day. (Note: CO levels fall overnight so morning readings may give low results.)
- Provide information (for example, a leaflet) about the risks to the unborn child of smoking when pregnant and the hazards of exposure to secondhand smoke for both mother and baby. Information should be available in a variety of formats.
- Explain about the health benefits of stopping for the woman and her baby. Advise her to stop – not just cut down.
- Explain that it is normal practice to refer all women who smoke for help to quit and that a specialist midwife or adviser will phone and offer her support. (Note: a specialist adviser needs to offer this support to minimise the risk of her opting out.)
- Refer all women who smoke, or have stopped smoking within the last 2 weeks, to NHS Stop Smoking Services. Also refer those with a CO reading of 7 ppm or above. (Note: light or infrequent smokers should also be referred,

even if they register a lower reading – for example, 3 ppm.) If they have a high CO reading (more than 10 ppm) but say they do not smoke, advise them about possible CO poisoning and ask them to call the free Health and Safety Executive gas safety advice line on: 0800 300 363.

- Use local arrangements to make the appointment and, in case they want to talk to someone over the phone in the meantime, give the NHS Pregnancy Smoking Helpline number: 0800 1699 169. Also provide the local helpline number where one is available.
- If her partner or others in the household smoke, suggest they contact NHS Stop Smoking Services. If no one smokes, give positive feedback.
- At the next appointment, check if the woman took up her referral. If not, ask if she is interested in stopping smoking and offer another referral to the service.
- If she accepts the referral, use local arrangements to make the appointment and give the NHS Pregnancy Smoking Helpline number: 0800 1699 169. Also provide the local helpline number where one is available.
- If she declines the referral, accept the answer in an impartial manner, leave the offer of help open. Also highlight the flexible support that many NHS Stop Smoking Services offer pregnant women (for example, some offer home visits).
- If the referral was taken up, provide feedback. Review at subsequent appointments, as appropriate.
- Where appropriate, for each of the stages above record smoking status, CO level, whether a referral is accepted or declined and any feedback given. This should be recorded in the woman's hand-held record. If a hand-held record is not available locally, use local protocols to record this information.

Recommendations for stopping smoking in pregnancy and following childbirth – Identifying pregnant women who smoke and referring them to NHS Stop Smoking Services – action for others in the public, community and voluntary sectors

(Who should take action – Those responsible for providing health and support services for the target group of women. This does not include midwives (see recommendation 1). It does include: GPs, practice nurses, health visitors and family nurses; Obstetricians, paediatricians, sonographers and other members of the maternity team (apart from midwives); Those working in youth and teenage pregnancy services, children's centres and social services; Those working in fertility clinics, dental practices, community pharmacies and voluntary and community organisations).

PH26

Recommendation 2

- Use any appointment or meeting as an opportunity to ask women if they smoke. If they do, explain how NHS Stop Smoking Services can help people to quit and advise them to stop.
- Offer those who want to stop a referral to NHS Stop Smoking Services.
- Use local arrangements to make a referral. Record this in the hand-held record. If a hand-held record is not available locally, use local protocols to record this information.
- Give the NHS Pregnancy Smoking Helpline number in case they want to talk to someone over the phone in the meantime: 0800 1699 169. Also provide the local helpline number where one is available.
- Those with specialist training should provide pregnant women who smoke with information (for example, a leaflet) about the risks to the unborn child of smoking when pregnant. They should also provide information on the hazards of exposure to secondhand smoke for both mother and baby and on the benefits of stopping smoking. Information should be available in a variety of formats.

NHS Stop Smoking Services – contacting referrals (pregnant women)

PH26

Recommendation 3

(Who should take action – NHS Stop Smoking Services specialist advisers).

- Telephone all women who have been referred for help. Discuss smoking and pregnancy and the issues they face, using an impartial, client-centred approach. Invite them to use the service. If necessary (and resources permitting), ring them twice and follow-up with a letter. Advise the maternity booking midwife of the outcome.
- Attempt to see those who cannot be contacted by telephone. This could happen during a routine antenatal care visit (for example, when they attend for a scan).
- Address any factors which prevent the women from using smoking cessation services. This could include a lack of confidence in their ability to quit, lack of knowledge about the services on offer, difficulty accessing them or lack of

suitable childcare. It could also include a fear of failure and concerns about being stigmatised.

- If women are reluctant to attend the clinic, consider providing structured self-help materials or support via the telephone helpline. Also consider offering to visit them at home, or at another venue, if it is difficult for them to attend specialist services.
- Send information on smoking and pregnancy to those who opt out during the initial telephone call. This should include details on how to get help to quit at a later date. Such information should be easily accessible and available in a variety of formats.

5.3 Current UK practice

There are a number of settings from which smokers can be identified and then referred to specialist smoking services. These settings include general practitioner (GP) surgeries, dentists, pharmacist, optometrist, and secondary care. These settings can be useful to intervene with smokers as they provide “teachable moments” (McBride, Emmons and Lipkus, 2003, p.156)⁸, “naturally occurring health events thought to motivate individuals to spontaneously adopt risk-reducing health behaviours” (McBride, Emmons and Lipkus, 2003, p.156)⁸.

In the ‘Stop smoking service delivery and monitoring guidance 2011/12’ (Department of Health, 2011b)⁹, the DH identifies data from the ‘Smoking Toolkit Study’ (www.smokinginengland.info)¹⁰, which suggests that most smokers are unidentified and are not being referred, as “the vast majority of smokers attempting to stop are continuing to choose the least effective methods of doing so” (Department of Health, 2011b, p.11)⁹. 18.6% attempt to stop unaided (least effective), and only 9% use a stop smoking service (most effective)⁹.

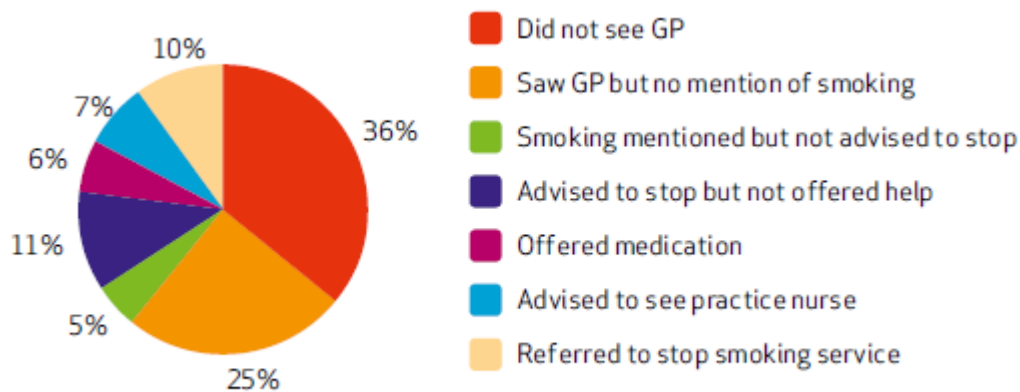
For those visiting their GP (over 60% of smokers visit their GP at least once a year), Figure 4.3.1 shows that only 10% were referred to a stop smoking service. For 25% of smokers, their GP did not raise the issue of smoking.

Figure 4.3.1: Smokers’ reports of GP contact and outcomes

⁸ McBride, C. M, Emmons, K. M, and Lipkus, I. M. (2003) Understanding the potential of teachable moments: the case of smoking cessation. Health Education Research. 18 (2), pp.156-170.

⁹ Department of Health (2011b) Stop smoking service delivery and monitoring guidance 2011/12

¹⁰ Smoking Toolkit Study, www.smokinginengland.info



Source: Department of Health (2011a)⁹

For those in secondary care, identification and referral also appears to be problematic. A Department of Health (DH) initiative was set up in 2009¹¹ due to the low numbers identified and referred in a secondary care setting. This involved encouraging providers to implement DH guidance on secondary care interventions for stopping smoking. Following this pilot, referrals increased by 4.5% (NCSCT, 2012)¹². In a review of this pilot (NCSCT, 2012)¹², the National Centre for Smoking Cessation and Training (NCSCT) stated this increase demonstrates that “there are a wealth of missed opportunities to intervene within the secondary care setting, and an enormous scope to improve and develop stop smoking support for hospital patients” (NCSCT, 2012, p.4)¹².

Finally, there are also several primary care focused quality and outcomes framework (QOF) indicators relating to and incentivising the identification and referral of smokers.

- SMOKING 5. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 15 months (NICE 2011 menu ID: NM38).
- SMOKING 6. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who smoke whose notes contain a record of an offer of support and treatment within the preceding 15 months (NICE 2011 menu ID: NM39).

¹¹ Department of Health (2009) ‘Stop Smoking Interventions in Secondary Care’

¹² National Centre for Smoking Cessation and Training (2012) ‘Stop Smoking Interventions in Secondary Care Final Report August 2012’.

- SMOKING 7. The percentage of patients aged 15 years and over whose notes record smoking status in the preceding 27 months.
- SMOKING 8. The percentage of patients aged 15 years and over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months (NICE 2011 menu ID: NM40).
- PP2 (cardiovascular disease – primary prevention). The percentage of patients diagnosed with hypertension (diagnosed after 1 April 2009) who are given lifestyle advice in the preceding 15 months for: increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet.
- ASTHMA 10. The percentage of patients with asthma between the ages of 14 and 19 years in whom there is a record of smoking status in the preceding 15 months.
- Information 5. The practice supports smokers in stopping smoking by a strategy which includes providing literature and offering appropriate therapy.

6 Suggested improvement area: brief interventions

6.1 Summary of suggestions

Brief interventions was one of the most common suggested areas of care with suggestions from 5 stakeholders. One stakeholder wished for brief interventions to be offered “at every opportunity”, however most others mentioned specific (and sometimes combined) sub-populations:

- Brief interventions in specific settings (secondary care and ophthalmology)
- Brief interventions for specific sub-groups (prisoners, and people with respiratory conditions (with asthma and COPD specifically mentioned).

The overarching theme was that brief interventions should routinely take place, in particular for certain settings and/or conditions, for example when attending secondary care for an asthma attack.

Although not necessarily requesting brief interventions, two stakeholders also felt that smoking cessation interventions should be offered as treatment for COPD, as it could offer primary, secondary and tertiary prevention. This could take the form of routine offers to stop smoking as a therapeutic intervention for COPD at long term condition reviews, emergency admissions etc.

NICE technical note: The process of identification, brief intervention and referral can be fluid and interdependent, therefore this area of care should be considered alongside the previous area of care (identification and referral).

6.2 Selected recommendations from development source

Recommendations from the development sources relating to the suggested improvement areas have been provisionally selected and are presented below to inform the Committee in their discussions.

Brief interventions and referral for smoking cessation in primary care and other settings

Please see section 5.2 for recommendations on brief interventions, identification and referral. In addition:

PH26

Recommendation 4 bullet point 5

Provide the woman with intensive and ongoing support (brief interventions alone are unlikely to be sufficient) throughout pregnancy and beyond. This includes regularly

monitoring her smoking status using CO tests. The latter may encourage her to try to quit – and can also be a useful way of providing positive feedback once a quit attempt has been made

Recommendation 8 bullet point 2

Ensure all midwives who are not specialist stop-smoking advisers are trained to assess and record people's smoking status and their readiness to quit. They should also know about the health risks of smoking and the benefits of quitting – and understand why it can be difficult to stop. In addition, they should know about the treatments that can help people to quit and how to refer them to local services for treatment. (Acquisition of this knowledge and skill set is part of level 1 training in brief stop-smoking interventions¹¹. Please note, midwives are not advised to carry out brief interventions with pregnant women. However, they are advised to use these skills to initiate a referral to NHS Stop Smoking Services.)

6.3 Current UK practice

Please see section 5.3 above for the current UK practice in relation to identification and referral.

The DH SSS delivery and monitoring guidance⁹ finds that “rates of intervention by healthcare professionals remains low” (Department of Health, 2011b, p.39)⁹ despite the fact that interventions are effective and cost-effective. It states that one of the reasons for this may be that the length of time suggested by NICE guidance of 10 minutes may be too long, as appointments with either GP or hospital consultants only last for 10-20 minutes. The DH guidance suggests that very brief advice (which may take no more than 30 seconds) may be effective in the context of a normal consultation.

Aveyard et al (2011)¹³ complete a systematic review and meta-analysis on brief opportunistic smoking interventions, as “intervention is not being implemented in practice in the majority of cases” (Aveyard et al, 2011, p.1066)¹³. A number of possible reasons for this were suggested, including physicians feeling that spending 5-10 minutes discussing smoking might be felt to be an “inefficient use of their time” (Aveyard et al, 2011, p.1066)¹³ as only around 2% of smokers achieve long-term abstinence. Aveyard et al (2011) conclude that “it appears that the US and English guidelines on smoking cessation are pushing physicians to intervene in a manner with which they do not feel comfortable and asking for more time than they think is reasonable” (Aveyard et al, 2011, p.1067)¹³.

In terms of the settings and conditions mentioned by stakeholders:

¹³ Aveyard, P., Begh, R., Parsons, A., and West, R. (2011) 'Brief opportunistic smoking cessation interventions: a systematic review and meta-analysis to compare advice to quit and offer of assistance'. *Addiction*, 107, p.1066-1073.

- The prevalence of smoking for those with COPD and asthma is higher than national averages, suggesting there is room for quality improvement for interventions such as brief interventions with these smokers.
- There is a strong association of smoking with age-related macular degeneration (AMD) (Department of Health, 2011b, p.13)⁹, however an article by Thomas et al (2007)¹⁴ states that “Few community optometrists routinely asked about smoking habits”.

¹⁴ Thompson, C., Harrison, R.A., Wilkinson, S.C., Scott-Samuel, A., Hemmerdinger, C., and Kelly, S.P. (2007) ‘Attitudes of community optometrists to smoking cessation: an untapped opportunity overlooked?’ *Ophthalmic and Physiological Optics*, 27 (4), pp.389-393.

7 Suggested improvement area: behavioural change support

7.1 Summary of suggestions

Behavioural change support was raised by three stakeholders (no stakeholders mentioned this as a 'standalone' area of care – each stakeholder mentioned this in relation to another concept, primarily that it should be offered alongside pharmacotherapy – see section 7 below).

7.2 Selected recommendations from development source

Recommendations from the development sources relating to the suggested improvement areas have been provisionally selected and are presented below to inform the Committee in their discussions.

Everyone who smokes or uses tobacco in any other form.

PH10

Recommendation 2 (key priority for implementation)

(Who should take action – Managers and providers of NHS Stop Smoking Services).

- Offer behavioural counselling, group therapy, pharmacotherapy or a combination of treatments that have been proven to be effective (see the list at the start of this section).
- Ensure clients receive behavioural support from a person who has had training and supervision that complies with the 'Standard for training in smoking cessation treatments' or its updates
- Provide tailored advice, counselling and support, particularly to clients from minority ethnic and disadvantaged groups. Provide services in the language chosen by clients, wherever possible.
- Ensure the local NHS Stop Smoking Service aims to treat minority ethnic and disadvantaged groups at least in proportion to their representation in the local population of tobacco users.

Recommendations for stopping smoking in pregnancy and following childbirth – NHS Stop Smoking Services – initial and ongoing support

PH26

Recommendation 4

(Who should take action – NHS Stop Smoking Services specialist advisers).

Note: Behaviour change support is not specifically mentioned in the ‘what action should they take’ section outlined below – it is mentioned within the ‘context’ section for this recommendation as follows: “Studies have shown that the following interventions are effective in helping women who are pregnant to quit smoking: cognitive behaviour therapy, motivational interviewing, structured self-help and support from NHS Stop Smoking Services”. Please see the guideline for the full list of recommendations.

7.3 Current UK practice

Behavioural change support is primarily offered alongside treatment such as pharmacotherapy. The DH SSS delivery and monitoring guidance (2011b)⁹ states that “Evidence has shown that a combination of behavioural support from a stop smoking adviser plus pharmacotherapy can increase a smoker’s chances of stopping by up to four times”⁹. Smokinginengland.info¹⁰ statistics show that “The proportion of smokers who made at least one quit attempt who used some form of cessation aid increased from 49.1% in 2007 to 53.5% in 2011; the increase was primarily in those who used a prescription with minimal behavioural support”¹⁰.

8 Suggested improvement area: Pharmacotherapy

8.1 Summary of suggestions

Some stakeholders felt that the chances of quitting increased with pharmacotherapy, however this was not reflected in standard practice and so this needed to be encouraged more. Both primary care and secondary care were mentioned. It was also commonly suggested that pharmacotherapy should be prescribed alongside behavioural change support (see section 7 above).

8.2 Selected recommendations from development source

Recommendations from the development sources relating to the suggested improvement area have been provisionally selected and are presented below to inform the Committee in their discussions.

Pharmacotherapy and other treatments

PH10

Recommendation 4 (key priority for implementation)

(Who should take action Healthcare professionals who advise on, or prescribe, nicotine replacement therapy (NRT), varenicline or bupropion).

- Offer NRT, varenicline or bupropion, as appropriate, to people who are planning to stop smoking.
- Offer advice, encouragement and support, including referral to the NHS Stop Smoking Service, to help people in their attempt to quit.
- NRT, varenicline or bupropion should normally be prescribed as part of an abstinence-contingent treatment, in which the smoker makes a commitment to stop smoking on or before a particular date (target stop date). The prescription of NRT, varenicline or bupropion should be sufficient to last only until 2 weeks after the target stop date. Normally, this will be after 2 weeks of NRT therapy, and 3–4 weeks for varenicline or bupropion, to allow for the different methods of administration and mode of action. Subsequent prescriptions should be given only to people who have demonstrated, on re-assessment, that their quit attempt is continuing.
- Explain the risks and benefits of using NRT to young people aged from 12 to 17, pregnant or breastfeeding women, and people who have unstable cardiovascular disorders. To maximise the benefits of NRT, people in these groups should also be strongly encouraged to use behavioural support in their quit attempt.

- Neither varenicline or bupropion should be offered to young people under 18 nor to pregnant or breastfeeding women.
- Varenicline or bupropion may be offered to people with unstable cardiovascular disorders, subject to clinical judgement.
- If a smoker's attempt to quit is unsuccessful using NRT, varenicline or bupropion, do not offer a repeat prescription within 6 months unless special circumstances have hampered the person's initial attempt to stop smoking, when it may be reasonable to try again sooner.
- Do not offer NRT, varenicline or bupropion in any combination.
- Consider offering a combination of nicotine patches and another form of NRT (such as gum, inhalator, lozenge or nasal spray) to people who show a high level of dependence on nicotine or who have found single forms of NRT inadequate in the past.
- Do not favour one medication over another. The clinician and patient should choose the one that seems most likely to succeed.
- When deciding which therapies to use and in which order, discuss the options with the client and take into account:
 - whether a first offer of referral to the NHS Stop Smoking Service has been made
 - contra-indications and the potential for adverse effects
 - the client's personal preferences
 - the availability of appropriate counselling or support
 - the likelihood that the client will follow the course of treatment
 - their previous experience of smoking cessation aids.
- (See also NICE technology appraisal guidance 123 on varenicline at www.nice.org.uk/TA123)

**Recommendations for stopping smoking in pregnancy and following childbirth
– Use of NRT and other pharmacological support**

PH26

Recommendation 5

(Who should take action – NHS Stop Smoking Services).

- Discuss the risks and benefits of NRT with pregnant women who smoke, particularly those who do not wish to accept other help from NHS Stop Smoking Services. Use only if smoking cessation without NRT fails. If they express a clear wish to receive NRT, use professional judgement when deciding whether to offer a prescription².
- Only prescribe NRT for use once they have stopped smoking (they may set a particular date for this).
- Only prescribe 2 weeks of NRT for use from the day they agreed to stop. Only give subsequent prescriptions to women who have demonstrated, on re-assessment, that they are still not smoking.
- Advise pregnant women who are using nicotine patches to remove them before going to bed.
- Neither varenicline or bupropion should be offered to pregnant or breastfeeding women.

Varenicline

NICE technology appraisal 123 recommendations 1.1 and 1.2

- 1.1 Varenicline is recommended within its licensed indications as an option for smokers who have expressed a desire to quit smoking.
- 1.2 Varenicline should normally be prescribed only as part of a programme of behavioural support.

8.3 Current UK practice

Pharmacotherapy is used for smoking cessation, however NRT can additionally be used for smoking reduction and temporary abstinence (MHRA, 2010)¹⁵.

Overall pharmacotherapy appears to be widely used, as the Health and Social Care Information Centre reported that “in 2011/12 just over nine in ten people using NHS Stop Smoking Services received some kind of pharmacotherapy” (Health and Social Care Information Centre, 2012a, p56)¹⁶:

¹⁵ Medicine and Healthcare Products Regulatory Agency (MHRA) ‘Nicotine replacement therapy and harm reduction’. Drug Safety Update 2010, 3 (7:6).

¹⁶ Health and Social Care Information Centre (2012a) ‘Statistics on NHS Stop Smoking Services: England, April 2011 – March 2012’.

- NRT was most commonly used, with 66% of people setting a quit date receiving this.
- 25% received varenicline only
- 1% received Bupropion only
- 1% received both NRT and varenicline
- Less than 0.1% had received both NRT and Bupropion”¹⁶.

Despite the high use, it is not clear that pharmacotherapy is being used effectively. An article by Brose et al (2011)¹⁷ finds that “smokers attending groups run by specialists using combination NRT or varenicline have a better chance of success than those being treated in primary care with one-to-one support and use of single NRT” (Brose et al, 2011, p.926)¹⁷. However, “the most effective forms of intervention are uncommon” (Brose et al, 2011, p.926)¹⁷.

An unpublished article by West et al (expected 2013)¹⁸ explains that “Recent evidence suggests that stop smoking advisors themselves are unaware of the relative utility of the different treatments”.

The DH SSS delivery and monitoring guidance⁹ points out the importance of having a range of options available to suit different individual and population preferences, and that “Ideally, stop smoking service providers should combine interventions that are appropriate to the needs, preferences and diversity of their local smoking population, while being particularly mindful of reaching those with health and social inequalities” (Department of Health, 2011b, p.32)⁹.

¹⁷ Brose, LS., West, R., McDermott, M.S., Fidler, J.A., Croghan, E., McEwen, A. (2011) ‘What makes for an effective stop-smoking service?’. *Thorax*, 66 (10), pp.924-926.

¹⁸ West, R., May, S., West, M, Croghan, E., McEwen, A. (unpublished – exp 2013) ‘Ten years of English Stop Smoking Services: how have they performed? An analysis of service monitoring data’.

9 Suggested improvement area: Holistic lifestyle advice

9.1 Summary of suggestions

Two dietary-focused organisations cited the link between smoking cessation and weight gain, pointing to evidence that smoking is used as a tool to control weight¹⁹. It was felt important to strike a balance between managing weight gain whilst ensuring this does not adversely impact upon reserves of willpower for smoking cessation. A third stakeholder suggested that smoking cessation advice should be integrated with other lifestyle advice in order to improve outcomes for patients, including weight and alcohol advice.

9.2 Selected recommendations from development source

Recommendations from the development sources relating to the suggested improvement area have been provisionally selected and are presented below to inform the Committee in their discussions.

Holistic lifestyle advice

No direct recommendations regarding this were found, however the following guideline contains a recommendation which may form the basis for a statement in this area.

PH10

Recommendation 2 bullet point 3

- Provide tailored advice, counselling and support, particularly to clients from minority ethnic and disadvantaged groups. Provide services in the language chosen by clients, wherever possible.

9.3 Current UK practice

The NCSCT finds that “Weight gain is a common consequence of stopping smoking but many experts in smoking cessation play this down and often the advice given to clients about possible weight gain and weight management strategies are inaccurate” (NCSCT, 2012, p.1)²⁰.

¹⁹ Farley, A.C., Hajek, P., Lycett, D., and Aveyard, P. 'Interventions for preventing weight gain after smoking cessation (Review)'. Cochrane Database of Systematic Reviews, 18 (1),

²⁰ National Centre for Smoking Cessation and Training (NCSCT) (2012) 'Some advice on managing smoking cessation related weight gain'.

10 Suggested improvement area: Measurement and audit

10.1 Summary of suggestions

Six stakeholders flagged the importance of capturing data wherever possible. This was the most popular suggested area of care. It was felt important to record smoking status, but it was also felt that recording data could be an effective way to measure outcomes, for example CO validation or follow-up smoking status.

10.2 Selected recommendations from development source

Recommendations from the development source relating to the suggested improvement area have been provisionally selected and are presented below to inform the Committee in their discussions.

Smoking cessation services

(Who should take action – Primary care trusts (PCTs), strategic health authorities (SHAs); Commissioners of publicly funded smoking cessation services.)

PH10 Recommendation 1 bullet points 4 and 5 (key priority for implementation)

- Set realistic performance targets for both the number of people using the service and the proportion who successfully quit smoking. These targets should reflect the demographics of the local population. Services should:
 - aim to treat at least 5% of the estimated local population of people who smoke or use tobacco in any form each year
 - aim for a success rate of at least 35% at 4 weeks, validated by carbon monoxide monitoring. This figure should be based on all those who start treatment, with success defined as not having smoked in the third and fourth week after the quit date. Success should be validated by a CO monitor reading of less than 10 ppm at the 4-week point. This does not imply that treatment should stop at 4 weeks.
- Audit performance data routinely and independently and make the results publicly available. Audits should also be carried out on exceptional results – 4-week quit rates lower than 35% or above 70% – to determine the reasons for unusual performance, and to help identify best practice and ensure it is being followed.

10.3 Current UK practice

Recording smoking status is common in primary care, as there are a number of QOF indicators which incentivise this (see section 5.3 above). Aveyard et al (2011)¹³ find that “while all UK primary care physicians record smoking status, only about 30% of smokers report that they receive advice to quit annually, and about 3% receive pharmacotherapy to support quitting” (Aveyard et al, 2011, p.1067)¹³.

In terms of the recording of outcomes, the SSS delivery and monitoring guidance⁹ outlines that previous guidance recommended minimum biochemical validation rates of 85% (of all reported four-week quits) (Department of Health, 2011b, p.34)⁹. However, it finds that although biochemical validation rates have increased since 2007/08, 2009/10 data indicates that, services are achieving biochemical validation rates of around 69%, with a wide variation in rates at PCT level. The guidance concludes that “There is therefore some way to go before reaching the recommended level” (Department of Health, 2011b, p.34)⁹.

11 Suggested improvement area: Smoking cessation service recommendation

11.1 Summary of suggestions

One stakeholder suggested a service orientated area of care, regarding the availability of stop smoking services. They felt that at present many services are only available on weekdays, and that the quality standard should include something regarding the availability of services in evenings and weekends.

11.2 Selected recommendations from development source

Recommendations from the development source relating to the suggested improvement area have been provisionally selected and are presented below to inform the Committee in their discussions.

Improving services for adults and retaining them

PH15

Recommendation 2

(Who should take action: Service providers (for example, PCTs, general practices, community services, local authorities and other organisations with a remit for tackling health inequalities)

- Provide flexible, coordinated services that meet the needs of individuals who are disadvantaged. For example, this could include providing drop-in or community-based services, outreach and out-of-hours services, advice and help in the workplace and single-sex sessions.
- Involve people who are disadvantaged in the planning and development of services. Seek feedback from the target groups on whether the services are accessible, appropriate and meeting their needs.
- Gain the trust of adults who are disadvantaged. Offer them proactive support. This could include helplines, brochures and invitations to attend services. It could also include providing GPs with postal prompts to remind them to monitor people who are disadvantaged and who have had an acute coronary event.
- Develop and deliver non-judgemental programmes to tackle social and psychological barriers to change. These should be

tailored to people's needs. For example, they could make use of social marketing techniques. (Social marketing involves using marketing and related techniques to achieve specific behavioural goals.)

- Ensure services are sensitive to culture, gender and age. For example, provide multi-lingual literature in a culturally acceptable style and involve community, religious and lay groups in its production. Where appropriate, offer translation and interpretation facilities. Promote services using culturally relevant local and national media, as well as representatives of different ethnic groups. Consider providing information in video or web-based format.
- Provide services in places that are easily accessible to people who are disadvantaged (such as community pharmacies and shopping centres) and at times to suit them.
- Provide support to ensure people who are disadvantaged can attend appointments (for example, this may include help with transport, postal prompts and offering home visits).
- Encourage and support people who are disadvantaged to follow the treatment that they have agreed to. For example, encourage them to use self-management techniques (based on an individual assessment) to solve problems and set goals. It could also involve providing vouchers for treatments (such as nicotine replacement therapy [NRT]). (For recommendations on the principles of behaviour change, see 'Behaviour change at population, community and individual levels' [NICE public health guidance 6].)
- Routinely search GP databases (and other electronic medical records) to generate lists of patients who have not collected repeat prescriptions or attended follow-up appointments. Make contact with them.
- Address factors that prevent people who are disadvantaged from using services (for example, they may have a fear of failure or of being judged, or they might not know what services and treatments are available).
- Support the development and implementation of regional and national strategies to tackle health inequalities by delivering local activities which are proven to be effective.

- Use health equity audits to determine if services are reaching people who are disadvantaged and whether they are effective¹. (For example, by matching the postcodes of service users to deprivation indicators and smoking prevalence.)

11.3 Current UK practice

The opening hours for smoking cessation services are decided on locally, therefore no evidence is presented in relation to this area of care.

The stakeholder suggesting this area of care states that many smoking cessation services are provided in healthcare settings which are open primarily during normal working hours, however no evidence is provided to support this point of view.

Appendix 1 Suggestions from stakeholder engagement exercise

ID	Stakeholder	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
24	NCSCT	Routine and systematic identification and referral of smokers	<p>It is well documented that over two thirds of smokers would like to stop. In addition there is good evidence to show that smokers expect to be asked about their smoking and that healthcare professionals can directly trigger quit attempts by delivering very brief advice to smokers they identify.</p> <p>The delivery of brief interventions / very brief advice is recommended in NICE guidance (PH1) and the DH service and monitoring guidance. In 2012 the National Centre for Smoking Cessation (NCSCT) released a 'very brief advice on smoking' online training module that is freely accessible www.ncsct.co.uk/vba</p>	<p>Despite the fact that support via stop smoking services offer smokers their greatest chance of quitting, results from the Smoking Toolkit Study have shown that this is the route less commonly used by smokers, with most smokers opting to try the least effective methods such as stopping unassisted or with the use of pharmacotherapy (bought over the counter) only. Therefore in order to improve the quality of quit attempts and to maximise the likelihood of quitting it is important that smokers are informed and proactively supported to access stop smoking services.</p> <p>Data from the Smoking Toolkit Study suggests that the subject of smoking is not routinely raised by GPs and therefore there is obvious scope for improvement in this area.</p> <p>Method of referral currently varies widely across England, with many areas not having formal referral pathways in place or remaining reliant on less efficient postal or fax referral mechanisms. Recent work undertaken within hospital settings has shown that electronic referral systems</p>	<p>NCSCT report following piloting of an electronic referral system in a secondary care setting: http://www.ncsct.co.uk/Content/FileManager/ncsct-secondary-care-final-report.pdf</p> <p>Results from the smoking toolkit study, which reports the quit methods used by smokers and the number of smokers who report having been asked about smoking by their GP: http://www.smokinginengland.info/</p> <p>Cochrane review on physician advice for smoking cessation showing positive impact of advice on cessation rates: http://ncsct-training.co.uk/interventions/resources/57e3cf-d6-759d-40e6-837a-3ed70aff89ae/PhysicianAdviceForSmokingCessation.pdf</p> <p>The traditional approach has been to focus on advising smokers to stop but a recent review of trials has shown that the offer of support is much more effective. Compared with no advice to smokers, the odds of quitting are 68% higher if stop smoking medication is offered and 217% higher with</p>

				<p>embedded within existing clinical IT systems provide an efficient and measurably way of recording and referring smokers.</p> <p>The quantity and quality of referrals could therefore be improved by ensuring that all health and social care staff undertake training in very brief advice (such as the free module provided by the NCSCT) and that local referral mechanisms are standardised and result in smokers being contacted by services and seen by a stop smoking practitioner quickly and efficiently.</p>	<p>offer of support, but in a large study across the whole of England, it was found that smokers were almost twice as likely to try to stop if they had been offered help by their GP, than if they had only been advised to stop. Just mentioning smoking or advising smokers to stop does not really trigger quit attempts. Virtually the same percentage made a quit attempt as those who didn't even see their GP. Offering help in the form of a referral, to see the practice nurse or the local stop smoking service or even the offer of prescription does make a significant difference however.</p> <p>Aveyard et al. (2011) Brief opportunistic smoking cessation interventions: A systematic review and meta-analysis to compare advice to quit and offer of assistance. <i>Addiction</i></p> <p>Paper by Kviz et al which showed that smokers expect to be asked about their smoking:</p> <p>Kvis FJ, Clark MA, Hope H, Davis AM. Patients' perceptions of their physician's role in smoking cessation by age and readiness to stop smoking. <i>Preventive Medicine</i>, 1997; 26(3): 340-349</p>
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3	DH Respiratory Programme	People attending hospital for emergency/unscheduled care for asthma should be offered help to quit before leaving hospital	An acute attack of asthma offers an important opportunity to support the patient with a range of messages about self-management, in line with the BTS/SIGN asthma guideline. This includes smoking to quit smoking because of the impact of smoking on asthma control	In the same way that pregnant women who smoke are systematically encouraged to quit and referred to appropriate services to help them do this, so patients with asthma would benefit from direct referral as part of the discharge process from A&E or a ward. This is something commissioners could build into contracts.	BTS acute asthma audit 2011: of people attending hospital for acute asthma care, 33% were current smokers, and 18.8% had been smokers.
4	DH Respiratory Programme	Smokers with respiratory disease (e.g. COPD or asthma) should be actively encouraged to attend stop smoking services at every opportunity	Stopping smoking will deliver improved outcomes in people with respiratory disease.	This is recommended in QOF, and the Quality standard should be consistent with and reinforce QOF. Continuing to smoke will reduce the effectiveness of other treatment in people with respiratory disease, which will lead to higher treatment costs overall. In asthma, higher doses of inhaled corticosteroids are required because they are less effective in people who smoke.	Purdy 2011 – for every 1% increase in smoking prevalence, there is a 1% increase in admissions for asthma BTS acute asthma audit 2011: of people attending hospital for acute asthma care, 33% were current smokers, and 18.8% had been smokers.

1 3	NHS Central Lancashire	<p>Need better control of smoking in prisons, to protect the health of inmates who do not smoke as well as those that do.</p> <p>Linked to the commissioning of smoking cessation services for prisoners as well as youth offending teams, in fact anyone in contact with probation team, youth offending team</p>	<p>There is a relatively high prevalence of smoking among prisoners and those in contact with probation services and youth offending services, so this provides an opportunity to access these high risk groups.</p> <p>For prisoners who do not smoke this creates an unhealthy environment.</p>	<p>Inadequate services for this high risk group create a health inequality. Services appear to be underfunded for this group compared to need.</p> <p>In many prisons access to smoking cessation medication is limited. Funding for NRT comes from the prescribing budget for prisons and every prisoner should be able to access NRT as described in NICE guidance. (In many areas NRT is rationed as it takes such a large proportion of the medicine budget).</p>	
2 2	PCR SUK	<p>People attending hospital for emergency/unscheduled care for asthma should be offered help to quit before leaving hospital</p>	<p>Smoking is associated with poor control of asthma, yet insufficient attention is being paid to offering help to stop in a hospital environment. This support is standard for smokers who become pregnant when they are receiving antenatal care, and a similar model could be developed for asthma patients. Likewise, smoking cessation support is more common in the context of cardiac rehab, than for respiratory patients.</p>	<p>There is a window of opportunity when people have an asthma attack that should be capitalised upon if the number of acute admissions is to be reduced.</p>	<p>Guidelines from Global Initiative for Asthma (GINA) http://www.ginasthma.org/</p> <p>BTS acute asthma audit 2011 http://www.brit-thoracic.org.uk/Portals/0/Audit%20Tools/Audit%20Asthma%20Summary%20Report%202011.pdf</p>

2 9	RCO phth	Provision of smoking cessation advice in Eye Care settings	There is good evidence (Ref 1-4) that several ophthalmic disorders (age-related macular degeneration (AMD), cataract, thyroid eye disorder) are causally associated with tobacco smoking.	There is good evidence that there is low awareness of the risk of eye disease and smoking amongst patients and public and youth in England.(Ref 5-7) Furthermore there is evidence from England and Australia that the low awareness of this risk is a novel and compelling reason for quitting smoking. (Ref 5-8). However there is room for improvement within the NHS in smoking cessation advice offered in optometry and ophthalmic settings in both community and secondary care.(Ref 9,10)	<ol style="list-style-type: none"> 1. Thornton J, Edwards R, Mitchell P, Harrison RA, Buchan I, Kelly SP. Smoking and age-related macular degeneration: a review of association. <i>Eye</i> 2005;19:935-44. http://www.ncbi.nlm.nih.gov/pubmed/16151432 2. Kelly SP, Thornton J, Edwards R, Sahu A, Harrison R. Smoking and cataract: review of causal association. <i>Journal of Cataract & Refractive Surgery</i> 2005;31:2395-404. http://www.ncbi.nlm.nih.gov/pubmed/16473237 3. Thornton J, Kelly SP, Harrison RA, Edwards R. Cigarette smoking and thyroid eye disease: a systematic review. <i>Eye</i> 2005http://www.ncbi.nlm.nih.gov/pubmed/16980921 4. Evans JR, Fletcher AE, Wormald RP. 28,000 Cases of age related macular degeneration causing visual loss in people aged 75 years and above in the United Kingdom may be attributable to smoking. <i>Br J Ophthalmol</i> 2005;89:550-3 http://www.ncbi.nlm.nih.gov/pubmed/15834082 5. Bidwell G, Sahu A, Edwards R, Harrison RA, Thornton J, Kelly SP. Perceptions of blindness related to smoking: a hospital-based cross-sectional study. <i>Eye</i> 2005;19:945-8. http://www.ncbi.nlm.nih.gov/pubmed/16151433 6. Moradi P, Thornton J, Edwards R, Harrison RA, Washington S, Kelly SP. Teenagers' perceptions of blindness related to smoking - novel message to a vulnerable
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				<p>group. British Journal of Ophthalmology 2007 http://www.ncbi.nlm.nih.gov/pubmed/17284473</p> <p>7. Moradi P et al Unpublished survey; School pupils' perceptions of blindness related to smoking - novel message to a vulnerable group. 2012 . Data on file at Royal College of Ophthalmologists</p> <p>8. Carroll T, Rock B. Generating Quitline calls during Australia's National Tobacco Campaign: effects of television advertisement execution and programme placement. Tob Control 2003;12:ii40-ii44. http://www.ncbi.nlm.nih.gov/pubmed/12878772</p> <p>9. Sahu A, Edwards R, Harrison RA, Thornton J, Kelly SP. Attitudes and behaviour of ophthalmologists to smoking cessation. Eye 2008 http://www.ncbi.nlm.nih.gov/pubmed/17016461</p> <p>10. Thompson C, Harrison RA, Wilkinson S, Hemmerdinger C, Kelly SP. Attitudes of community optometrists to smoking cessation: An untapped opportunity overlooked? Ophthalmic Physiol Opt 2006. http://www.ncbi.nlm.nih.gov/pubmed/17584290</p>
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2	DH Respiratory Programme	Support for smoking cessation as a treatment for COPD	<p>Stopping smoking is an important primary prevention intervention for COPD.</p> <p>In COPD, stopping smoking is also an important treatment option because smoking cessation at any stage of disease slows progression in lung function decline, reduces symptoms and increases survival.</p> <p>As a treatment, smoking cessation is considerably more cost effective than pharmacotherapy.</p> <p>Long term condition reviews, consultations triggered by acute exacerbations and emergency admission to hospital all offer powerful opportunities to support people to stop smoking. An offer of stop smoking support as a therapeutic option should be routine in these settings.</p>	<p>Support to quit smoking is not offered routinely to people with COPD, particularly during admission to hospital. This is a wasted opportunity to make every contact count.</p>	<p>The NHS Companion Document to the Outcomes Strategy for COPD and Asthma recommends routine and repeated support to stop smoking as an important therapeutic intervention.</p> <p>This recommendation is reflected in the NICE Quality Standard for COPD</p>
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1 9	PCR SUK	Support for smoking cessation as a treatment for COPD	<p>Stopping smoking is an important primary prevention intervention for COPD.</p> <p>In COPD, stopping smoking is also an important treatment option because smoking cessation at any stage of disease slows progression in lung function decline, reduces symptoms and increases survival.</p> <p>As a treatment, smoking cessation is considerably more cost effective than other pharmacotherapy.</p> <p>Long term condition reviews, consultations triggered by acute exacerbations and emergency admission to hospital all offer powerful opportunities to support people to stop smoking. An offer of stop smoking support as a therapeutic option should be routine in these settings.</p>	<p>Support to quit smoking is not offered routinely to people with COPD, particularly during admission to hospital. This is a wasted opportunity to make every contact count.</p> <p>In addition people with COPD may need repeat quit attempts and support to do so. Smoking cessation impacts on many LTCs so needs to be a key component of LTC management</p>	<p>The NHS Companion Document to the Outcomes Strategy for COPD and Asthma recommends routine and repeated support to stop smoking as an important therapeutic intervention.</p> <p>This recommendation is reflected in the NICE Quality Standard for COPD</p>
1 8	PCR SUK	All primary care staff should be trained to deliver brief interventions in smoking cessation and to be able to offer referral for support and treatments to quit	Many primary care staff are not raising the subject of smoking with smokers. Yet there is evidence that a brief intervention followed by the offer of behavioural change support and treatment can be effective.	Brief advice appears to be most effective when followed up by the offer of support and stop smoking medications .	Brief opportunistic smoking cessation interventions: a systematic review and meta-analysis to compare advice to quit and offer of assistance. Paul Aveyard, et al UK Centre for Tobacco Control Studies, Primary Care Clinical Sciences, University of Birmingham, Addiction 12/2011; 107(6):1066-73. DOI:10.1111/j.1360-0443.2011.03770.x

7	RCP	2 Increasing provision of nicotine addiction treatments and other cessation support to smokers who are treated in acute hospital trusts	Opportunities to encourage the use of nicotine addiction treatments (NATs) and other cessation support in secondary care are also regularly missed. [2] By increasing the provision of NATs and other support to patients who are admitted to acute hospital wards, the secondary care management of smoking could be substantially enhanced. All smokers who are admitted to hospital should have smoking cessation discussed with them and, if desired, should be prescribed NATs and be referred for behavioural smoking cessation support. Ideally, the latter should be initiated prior to hospital discharge and continued afterwards to maximise the impact of such support on abstinence from smoking. [2]		
1 1	UKC TCS	2 Increasing provision of nicotine addiction treatments and other cessation support to smokers who are treated in acute hospital trusts	Opportunities to encourage the use of nicotine addiction treatments (NATs) and other cessation support in secondary care are also regularly missed. [2] By increasing the provision of NATs and other support to patients who are admitted to acute hospital wards, the secondary care management of smoking could be substantially enhanced. All smokers who are admitted to hospital should have smoking cessation discussed with them and, if desired, should be prescribed NATs and be referred for behavioural smoking cessation support. Ideally, the latter should be initiated prior to hospital		

			discharge and continued afterwards to maximise the impact of such support on abstinence from smoking. [2]		
26	NCSCT	Provision of stop smoking medication as first line treatments	<p>The use of stop smoking pharmacotherapy provided by a healthcare professional doubles the chances of quitting and is therefore an essential element of any support package. (This should however be combined with behavioural support to have maximum effect - quadrupling the chances of quitting).</p> <p>NICE guidance (PH10) and the DH service and monitoring guidance both recommend that all approved medications (varenicline, bupropion and nicotine replacement therapy (NRT) including combination) be available to smokers as first line treatments.</p>	<p>Availability of stop smoking medications, in particular varenicline, as first line treatments is variable across England. In some areas smokers are expected to have attempted to stop using NRT before being able to access varenicline. Given that varenicline is the most effective medication, with combination NRT being the only comparable option in terms of quit rates, it is important that smokers have access to the full range of options irrespective of the number of previous quit attempts.</p>	<p>NCSCCT briefings on:</p> <p>Combination NRT Varenicline: effectiveness and safety Cost-effectiveness of pharmacotherapy for smoking cessation</p> <p>http://www.ncsct.co.uk/resources/briefings</p> <p>Cochrane reviews to support the use of stop smoking pharmacotherapy:</p> <p>http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD000146.pub4/abstract</p> <p>http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006103.pub6/abstract</p> <p>DH 2011/12 Local stop smoking service, service and monitoring guidance – see pgs. 30 & 52 re. pharmacotherapy use recommendations: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_125389</p>

6	RCP	1 Increasing provision of nicotine addiction treatments to smokers who present in primary care	<p>There is strong evidence that, although cessation advice-giving in primary care has increased in recent years, there has not been a similar concurrent increase in the proportion of smokers who are prescribed effective treatments for nicotine addiction. Although there was an approximate doubling of advice-recording and tripling of advice-giving at the time the Quality and Outcomes Framework (QOF) was introduced, there was no concurrent increase in the rate of provision of nicotine addiction treatments to primary care patients.[1] Those nicotine addiction treatments which are available on prescription are effective and by encouraging their provision to all smokers, the management of smoking would be greatly improved.</p>		<p style="text-align: center;">Reference List</p> <p>[1]Coleman, T., et al., Impact of contractual financial incentives on the ascertainment and management of smoking in primary care. <i>Addiction</i>, 2007. 102: p. 803-808.</p> <p>[2]Rigotti, N.A., Clair, C., Munafò, M.R. & Stead, L.F. (2012). Interventions for smoking cessation in hospitalised patients. <i>Cochrane Database Syst Rev</i>; 5: CD001837.</p> <p>[3]Fiore, M.C., D.K. Hatsukami, and T.B. Baker, Effective tobacco dependence treatment. <i>JAMA</i>, 2002. 288(14): p. 1768-1771.</p> <p>[4]Jo Leonardi-Bee, Mirriam Lisa Jere, John Britton. Exposure to parental and sibling smoking and the risk of smoking uptake in childhood and adolescence: a systematic review and meta-analysis <i>Thorax</i> 2011;66:847e855. doi:10.1136/thx.2010.153379</p>
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10	UKC TCS	1 Increasing provision of nicotine addiction treatments to smokers who present in primary care	<p>There is strong evidence that, although cessation advice-giving in primary care has increased in recent years, there has not been a similar concurrent increase in the proportion of smokers who are prescribed effective treatments for nicotine addiction. Although there was an approximate doubling of advice-recording and tripling of advice-giving at the time the Quality and Outcomes Framework (QOF) was introduced, there was no concurrent increase in the rate of provision of nicotine addiction treatments to primary care patients.[1] Those nicotine addiction treatments which are available on prescription are effective and by encouraging their provision to all smokers, the management of smoking would be greatly improved.</p>		<p style="text-align: center;">Reference List</p> <p>[1]Coleman, T., et al., Impact of contractual financial incentives on the ascertainment and management of smoking in primary care. <i>Addiction</i>, 2007. 102: p. 803-808.</p> <p>[2]Rigotti, N.A., Clair, C., Munafò, M.R. & Stead, L.F. (2012). Interventions for smoking cessation in hospitalised patients. <i>Cochrane Database Syst Rev</i>; 5: CD001837.</p> <p>[3]Fiore, M.C., D.K. Hatsukami, and T.B. Baker, Effective tobacco dependence treatment. <i>JAMA</i>, 2002. 288(14): p. 1768-1771.</p> <p>[4]Jo Leonardi-Bee, Mirriam Lisa Jere, John Britton. Exposure to parental and sibling smoking and the risk of smoking uptake in childhood and adolescence: a systematic review and meta-analysis <i>Thorax</i> 2011;66:847e855. doi:10.1136/thx.2010.153379</p>
15	NHS Central Lancashire	Encourage the integration of stop smoking advice and services with other lifestyle services around weigh management and alcohol	Many of these lifestyle services are viewed as independent, but many individuals need several services, and integration would improve outcomes for patients	Services need to be better aligned to outcomes for patients.	

2 3	dom UK	Weight management and achievement of a healthy body weight using diet, physical activity & behaviour change.	Weight management: there is evidence that smoking may be used as a tool to manage weight, and smoking cessation is recognised as a risk for weight gain.	Prevalence of obesity and overweight in UK adults and children is high and recognised as a serious ongoing health concern.	Please see the National Child Measurement Programme statistics for evidence on child overweight and obesity (http://www.ic.nhs.uk/ncmp), and the Department of Health Public Health White Paper (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121941 http://www.ic.nhs.uk/ncmp) and report on the health and wellbeing of the population (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122088).
3 4	BDA	Smoking cessation: supporting people to stop smoking	Weight gain accompanies smoking cessation in 83% of quitters (Lycett et al, 2011). It is unclear whether this weight gain leads to relapse to smoking but it is an issue frequently raised with stop smoking practitioners by smokers trying to quit who are fearful of the weight they will gain. It is also associated with an increased risk of diabetes in the first 3-5 years following smoking cessation compared with those who continue to smoke (Wannamathee et al, 2001, Davey-Smith et al, 2005, Yeh et al, 2010).	<p>We do not know whether trying to control weight at the same time as quitting smoking may reduce the chances of quitting successfully. Evidence suggests that hunger increases urges to smoke (Cheskin et al 2005, Leeman et al, 2010), and people who gain most weight are more likely to succeed in quitting smoking (Hall et al, 1992). This suggests that avoiding hunger and ameliorating cigarette cravings with food may enhance smoking abstinence.</p> <p>Current recommendations therefore are that weight should only be discussed if the quitting smoker raises the subject, in which case practitioners should advise quitters to establish their quit status before attempting to control weight. In reality, a national survey of 484 stop smoking practitioners revealed 76% of</p>	<p>Please see the cochrane review: http://summaries.cochrane.org/CD006219/interventions-for-preventing-weight-gain-after-smoking-cessation</p> <p>This suggested that the most promising approach to prevent about half of the expected weight gain 12 months after quitting was to provide individually tailored dietary and activity advice with goal setting and feedback and 600kcal dietary energy prescriptions, but a detrimental effect on quitting could not be ruled out as the sample size was not large enough to detect this. Estimates were imprecise and confidence intervals were wide.</p> <p>Education to change diet, activity and behaviour which wasn't individualised was ineffective to prevent weight gain at 12</p>

				<p>practitioner provide quitting smokers with general healthy eating advice i.e. to choose healthy foods when they get hungry (McEwen, 2010).</p> <p>However recent Cochrane review evidence suggests that this may be a harmful practice but evidence is too unclear to make clear clinical recommendations.</p>	<p>months and resulted in a significant reduction in quit rates, but again estimates were too imprecise to be conclusive.</p> <p>I propose that the NICE guidelines take into consideration the uncertainty surrounding preventing weight gain during smoking cessation and that the recommendation to establish a quit attempt before attempting to control weight continues to be upheld. However given the high demand for help to prevent weight gain in stop smoking clinics I propose a pragmatic approach such that if clinical judgement considers it would be more harmful to delay weight management than wait until a quit attempt has been established, patients should be referred to weight management services which provide the individualised support described above.</p> <p>Yeh HC, Duncan BB, Schmidt MIs, Wang NY, Brancati FL. Smoking, Smoking Cessation, and Risk for Type 2 Diabetes Mellitus. <i>Annals of Internal Medicine</i>. 2010;152(1):10-17.</p> <p>Wannamethee SG, Shaper AG, Perry IJ. Smoking as a modifiable risk factor for type 2 diabetes in middle-aged men. <i>Diabetes Care</i> 2001; 24 (9) 1590–1595</p> <p>McEwen A. NCSCT Annual Surveys of commissioners, managers and practitioners 2010: Preliminary results.</p> <p>Lycett, D., Munafo, M., Johnstone, E.,</p>
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1	NCT	Smoking cessation in pregnancy, particularly interventions that are effective in helping women who have experienced greater disadvantage to stop smoking	Pregnancy is a time when families use the health service regularly for several months and when women and their partners are often highly motivated to address issues affecting their health in order to give their baby a good start in life. Antenatal care and support sessions provide a potential opportunity to influence health-related behaviours. As well as the chance to improve the outcome of the pregnancy, the perinatal period has often been targeted as a time when long-term health can be influenced, particularly for those who are vulnerable or disadvantaged, where the impact is likely to be greatest.	There is clear widely accepted evidence that smoking adversely affects outcomes for women and their babies, but many women are still smoking at the time their babies are born. Furthermore, women who smoke are more likely to be disadvantaged in other ways. This is, therefore, a key area where interventions that have been shown to be effective can potentially address health inequalities. This may include innovative interventions, for example directed at partners as well as women during pregnancy or that aim to reduce a baby's environmental exposure.	<p>Even though there is clear evidence that smoking adversely affects outcomes for women and their babies, around 13% of mothers are smokers at the time their babies are born [1]. The prevalence of cigarette smoking is highest in low income households and lowest in high income households [2] and women who have experienced greater disadvantage, for example leaving education early or having a low income, are more likely to smoke before pregnancy [3].</p> <ol style="list-style-type: none"> 1. The NHS Information Centre. Statistics on women's smoking status at time of delivery: England, Quarter 1, 2012/13. Published 30/08/12. Available at http://www.ic.nhs.uk/pubs/wsstd1213q1. Accessed 05/11/12. 2. The NHS Information Centre. Statistics on smoking - England, 2012. Published 16/08/12. Available at http://www.ic.nhs.uk/pubs/smoking12. Accessed 05/11/12. <p>Graham H, Hawkins SS, Law C. Lifecourse influences on women's smoking before, during and after pregnancy. <i>Social Science and Medicine</i> 2010; 70(4): 582-587.</p>
5	DH Respiratory Programme	All patients who attend for emergency/unscheduled care for asthma to have their	The BTS acute asthma audit shows that the prevalence of current or past smoking amongst people attending hospital is high	Smoking status is not something routinely collected by healthcare settings treating acute asthma. Collecting these data will help clinicians and service managers to recognise the link between smoking and asthma control, and seek to work across	BTS acute asthma audit 2011: of people attending hospital for acute asthma care, 33% were current smokers, and 18.8% had been smokers.

	e	smoking status recorded, and for this to be audited		secondary and primary care boundaries to address this issue with appropriate service provision. Such an audit could be required by commissioners in contracts.	
8	RCP	3 Increasing primary care health professionals' awareness of women's smoking status whilst pregnant	<p>More than half of women who smoke at the outset of pregnancy will make an attempt to stop smoking during their gestation. Pregnancy is probably the most motivating event in most women smokers' lives and is possibly, with respect to stopping smoking, more motivating than any other life event.</p> <p>There is good evidence that when health professionals are aware of patients' smoking status, they are much more likely to raise the topic of smoking and offer evidence based cessation support.[3] Merely having accurate, clearly noticeable records of smoking status can have an impact on smoking cessation rates. [3] Regrettably, although the recording of smoking status in primary care medical records has increased markedly in recent years, the ascertainment and recording of smoking status during women's gestation remains low and only approximately one third of pregnant women have a record of their smoking status entered into their medical records whilst they are pregnant (Tata, L. Personal communication, data from the THIN database).</p> <p>Increasing recording of smoking status in primary care medical records would</p>		

			<p>result in more widespread provision of effective smoking cessation interventions to pregnant women [3], improving both their health and their children's health. As children who live with mothers who smoke are twice as likely to become smokers themselves [4] improving the treatment of pregnant smokers could have a substantial cross-generational impact.</p>		
1 2	UKC TCS	3 Increasing primary care health professionals' awareness of women's smoking status whilst pregnant	<p>More than half of women who smoke at the outset of pregnancy will make an attempt to stop smoking during their gestation. Pregnancy is probably the most motivating event in most women smokers' lives and is possibly, with respect to stopping smoking, more motivating than any other life event. There is good evidence that when health professionals are aware of patients' smoking status, they are much more likely to raise the topic of smoking and offer evidence based cessation support.[3] Merely having accurate, clearly noticeable records of smoking status can have an impact on smoking cessation rates. [3] Regrettably, although the recording of smoking status in primary care medical records has increased markedly in recent years, the ascertainment and recording of smoking status during women's gestation remains low and only approximately one third of pregnant women have a record</p>		

			<p>of their smoking status entered into their medical records whilst they are pregnant (Tata, L. Personal communication, data from the THIN database).</p> <p>Increasing recording of smoking status in primary care medical records would result in more widespread provision of effective smoking cessation interventions to pregnant women [3], improving both their health and their children's health. As children who live with mothers who smoke are twice as likely to become smokers themselves [4] improving the treatment of pregnant smokers could have a substantial cross-generational impact.</p>		
20	PCR SUK	Every practice to audit the number of patients with a respiratory condition who are current smokers and for numbers to be audited each year to compare to the general population	Current QOF requires respiratory patients to be asked whether they smoke, but there is no requirement to record or report how many do smoke.	Once this information is monitored, it is also possible to audit the number of people with a respiratory condition who smoke and have had an admission, so it will help with risk stratification and targeting resources/ interventions. If interventions to reduce smoking in people with respiratory disease are being effective, one would expect rates to come down over time.	Purdy et al J Health Serv Res Pol 2011 – for every 1% increase in smoking population there is a 1% rise in hospital admissions for asthma

2 1	PCR SUK	All patients who attend for emergency/unscheduled care for asthma to have their smoking status recorded, and for this to be audited	Evidence from BTS acute asthma audit suggests that 50% of people receiving care for acute asthma were past or current smokers. This compares with a 21% smoking rate in the wider population	Reducing smoking in people with respiratory disease could improve the control of their condition (e.g. asthma) , in COPD it could slow the pace of deterioration, and reduce hospital admissions.	BTS acute asthma audit 2011 http://www.brit-thoracic.org.uk/Portals/0/Audit%20Tools/Audit%20Asthma%20Summary%20Report%202011.pdf
2 7	NCS CT	Monitoring and reporting stop smoking service activity	<p>Currently activity of stop smoking services is measured nationally through the submission of data to the NHS IC. It is unclear whether this will continue on a national scale but it is important that data collection remains locally as this can be used to monitor trends, quality of service provision and inform commissioning plans.</p> <p>It is also important that there remains a focus on biochemically validating quit status as this increases the reliability of the data collected. The use of CO-validation to verify a minimum of 85% is recommended by the DH in the service and monitoring guidance.</p>	<p>Current rates of CO-validation are greatly variable across England. In 2011/12 these rates ranged from 10% - 97%.</p> <p>Without continued data collection it will not be possible to measure service activity and outcomes to inform commissioning and quality improvement.</p>	2011/12 statistics on stop smoking services: http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/nhs-stop-smoking-services/statistics-on-nhs-stop-smoking-services--england-april-2011-to-march-2012

2 8	NCS CT	Independent auditing of stop smoking service provision	<p>Whilst many services have their own internal quality assurance systems there is no requirement for service delivery to be independently reviewed, unlike other areas of the healthcare system.</p> <p>Independent auditing seeks to verify reported outcomes and offer objective assurance that minimum quality standards are being met. This provides greater assurance for commissioners, the providers and most importantly for the smokers using services. A consistent approach to independent auditing allows national comparison and reduces variation in definitions of quality and auditing.</p>	<p>Independent auditing is likely to become increasingly important as services adapt and change to meet local priorities.</p> <p>Independent auditing offers a learning process through which areas of effective practice and areas for improvement can be identified to inform action planning in order to improve the quality of service provision. This complements and reinforces any internal quality assurance processes already in place.</p>	<p>NCSCT report on developing and testing an independent auditing service for stop smoking providers: http://www.ncsct.co.uk/Content/FileManager/ncsct-audit-report-sept-2012.pdf</p>
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3 0	Pfizer	<p>Pfizer welcomes the draft topic overview of the proposed smoking cessation quality standard, and notes the inclusion of existing indicators relating to quality, including all the smoking-related QOF indicators which are geared towards incentivizing primary care practices to produce a high quality standard of care. Pfizer welcomes the inclusion of these indicators as primary care practices will play a crucial role in identifying and offering smoking cessation interventions to patients. There were over 300 million primary care consultations</p>	<p>There is good evidence from NHS smoking cessation statistics that measurement of smoking status 4 weeks after commencing an abrupt quit attempt is a reasonable indicator of patient smoking cessation outcome. This view is supported by one of the local basket of indicators (7.1 - the number of smokers who had successfully quit at the four week follow up) identified in the Smoking Cessation Quality Standard topic overview.</p> <p>It therefore seems reasonable to incentivize GP practices around recording 1) uptake of smoking cessation therapy and 2) patient smoking cessation outcome, rather than limiting the incentive to recording that a smoking cessation intervention was offered if the intention is to reduce adult smoking prevalence from 21.2% to 18.5% by the end of 2015 (Healthy Lives Healthy People, 2011). In addition, there is evidence from the UK smoking cessation service that self-reported quitting at 4 weeks after target quit date is associated with higher failure rates at 1 year after the attempt than patients with a CO2-validated 4-week quit outcome (Ferguson, 2005). Therefore a CO2-validated 4-week quit attempt is a desirable quality indicator for a primary care practice.</p> <p>There is also evidence from the UK</p>	<p>To address the issues outlined in the preceding column, the following quality indicators for primary care practices are proposed for inclusion in the smoking cessation quality standard:</p> <ul style="list-style-type: none"> • The percentage of patients aged 15 years and over with a record of treatment for smoking cessation with the preceding 27 Months. • The percentage of patients aged 15 years and over with a CO2-validated record of quit status at 4 weeks post-target quit date following initiation of smoking cessation treatment. • The percentage of patients aged 15 years and over with a CO2-validated record of quit status at 12 weeks post-target quit date following initiation of smoking cessation treatment. • The percentage of patients aged 15 years and over with a record of 'current smoker' at 52 weeks post-target quit date following initiation of smoking cessation treatment, who are offered another smoking cessation intervention. <p>If primary care practices are incentivised to assist patients by providing smoking cessation therapy and follow-up using CO2-validated monitoring to achieve smoking cessation outcomes rather than simply making an offer of a smoking cessation intervention, this will improve the quality of care provided to patients and will likely increase the number of</p>	<p>References:</p> <ol style="list-style-type: none"> 1. The Health and Social Care Information Centre. Trends in Consultation Rates in General Practice 1995 to 2008: Analysis of the QResearch® database. 2009. 2. The Health and Social Care Information Centre. Statistics on NHS Stop Smoking Services: England, April 2011 – March 2012 3. DH. Healthy Lives, Healthy People – A Tobacco Control Plan for England. HM Government 2011. 4. Ferguson J, Bauld L, Chesterman J, Judge K. The English smoking treatment services: one-year outcomes. <i>Addiction</i>. 2005 Apr;100 Suppl 2:59-69. 5. Hughes JR et al. Shape of the relapse curve and long-term abstinence among untreated smokers. <i>Addiction</i> 2004; 99: 29–38.
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<p>in 2008 in England (HSCIC, 2009) while just 816 000 smokers accessed the NHS smoking cessation services and set a quit date in 2011-12 (HSCIC, 2012). This indicates the scale of the opportunity for primary care practitioners (GPs and nurses) to identify smokers amongst their patients and offer them smoking cessation interventions.</p> <p>However, a key area for quality improvement are the QOF indicators for smoking cessation, particularly SMOKING 8 (the percentage of patients aged 15 years and over</p>	<p>smoking cessation service that 75% of smokers initiating a quit attempt will be smoking again 1 year after the attempt, with 39% of quit failures responding that they relapsed within 12 weeks of the 4-week quit date (Ferguson, 2005). This suggests that a follow-up appointment to assess smoking status at 12 weeks may help a significant number of smokers to remain smoke-free at this time-point which may in turn facilitate a longer-term quit for many patients.</p> <p>Furthermore, most smokers will make between 5 and 7 quit attempts before they succeed (Hughes 2004). Therefore where a prior smoking cessation attempt exists in the primary care practice records, current smoking status should be recorded where possible at future visits. If patients are still smoking a year after the recorded initiation of a smoking cessation attempt, it is reasonable to offer them a second smoking cessation intervention.</p>	<p>patients able to remain smoke free in the longer-term. Furthermore, if primary care practices are actively engaged in monitoring smoking status in patients with a record of a previous quit attempt, they will be able to identify those patients eligible and motivated for a second quit attempt. These measures may assist smoking cessation services in reducing the local prevalence of smoking and thereby contribute to the goal of reducing the national smoking prevalence in England.</p>
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	<p>who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months) and INFORMATION 5 (the practice supports smokers in stopping smoking by a strategy which includes providing literature and offering appropriate therapy.) Pfizer believes that these indicators do not adequately incentivize primary care practices to focus on smoking cessation as a patient outcome, but instead focus the practice on the process of offering the smoking cessation intervention itself.</p>			
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3 3	Pfizer	<p>Pfizer notes that the draft smoking cessation quality standard topic overview refers, on p.1, to the fact that 'this will be an NHS facing quality standard, and as such will only include services provided or commissioned by the NHS'. However, responsibility for commissioning smoking cessation services is due to transfer from PCTs to local authorities in 2013, therefore the scope of this quality standard should be extended to cover the latter organisations. In addition, while local authorities may still commission smoking cessation</p>	<p>Currently, there are no quality indicators related to measuring smoking abstinence outcomes (neither 4 weeks nor 12 weeks post target quit date) in the public health outcomes framework for local health authorities (Kelly, 2012). Without quality indicators relating to patient smoking cessation outcomes, it is unclear how the adult smoking prevalence metrics included in the public health outcomes framework can be reduced other than by primary prevention interventions. Since the latter do not cover people who are currently smoking, there appears to be a big gap in the public health strategy to reduce smoking prevalence</p>	<p>Since local authorities will from 2013 be responsible for commissioning smoking cessation services, it is vital to ensure that the quality of service commissioned by local authorities (whether NHS or new provider) is maintained and improved in comparison to existing PCT-commissioned smoking cessation services. Therefore the smoking cessation quality standard should include quality indicators to ensure that smoking cessation outcomes are core performance metrics for which local health authorities are accountable, e.g. 4-week and 12-week quit rates post target quit date, and follow-up and recording of those who have failed a quit attempt.</p>	<p>References:</p> <p>1. Kelly P, 2012. Public Health England: What the future holds for stop smoking services. UKNSCC 2012. http://www.uknsc.org/uknsc2012_presentation_98.php</p>
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		services from the NHS, they may also commission providers from outside the NHS. The proposed smoking cessation quality standard should also cover these new providers.			
1 7	PCR SUK	Smokers to have access to smoking cessation services in evenings and at weekends	Many smoking cessation services are provided in healthcare settings which are open primarily during normal working hours.	People who are restricted by working hours are less likely to engage with services if they have to take time off work to attend. Furthermore smoking cessation has been shown to be more effective in groups than on one-to-one basis, so sessions should take place at times that groups can be gathered.	Brose et al. (2011). What makes for an effective stop-smoking service? Thorax, 66(10), 924-926. doi: 10.1136/thoraxjnl-2011-200251
1 6	PCR SUK	Smokers to have access to smoking cessation advisers who are recruited for their motivation and skills to support smokers to quit, and to be trained to NCSCT minimum standards	Many professionals working as smoking cessation advisers have the role delegated to them and do not necessarily have the motivation or skills to perform the role effectively.	It is unlikely that someone that has a responsibility for smoking cessation delegated to them will be as effective as someone who is recruited for their motivational/empathy/listening/'soft' skills. And training them in the role is key in order that smokers receive advice and support of a consistent quality.	Brose et al. (2011). What makes for an effective stop-smoking service? Thorax, 66(10), 924-926. doi: 10.1136/thoraxjnl-2011-200251 www.ncsct.co.uk/ Research is needed to evaluate the characteristics of stop smoking advisors with successful outcomes

2 5	NCS CT	Training of stop smoking practitioners	<p>In order to provide effective stop smoking support it is important that stop smoking practitioners are trained and competent in delivering the evidence based behaviour change techniques for smoking cessation.</p> <p>The DH service and monitoring guidance recommends that all stop smoking practitioners are NCSCCT certified and trained to NCSCCT standards.</p>	<p>Quit rates at practitioner level are not reported nationally however a wide range in the quit rates reported at service level are evident. In 2011/12 self-reported quit rates ranged from 33.7% to 70.7%. The lower range is of concern given that one would expect a self-reported quit rate of 35% amongst smokers quitting with only the use of pharmacotherapy from a healthcare professional. Services reporting quit rates below this are therefore not only providing no added value to quit attempts but, it could also be argued, are having a negative impact.</p> <p>It is known that practitioners for whom smoking cessation is their full time role have greater success rates than those for whom smoking cessation is only one part of their job such as community practitioners e.g. practice nurses, pharmacy staff etc. Given that the majority of support is now provided through community practitioners it is therefore imperative that these advisers are trained to minimum standards.</p> <p>There is also a wide variation in local minimum training requirements for stop smoking practitioners. In 2009 the NCSCCT was commissioned by the Department of Health to develop and provide training and national minimum standards for stop smoking practitioners to help reduce the gap in the quality of support provided. NCSCCT certification should therefore be a</p>	<p>Findings from the NCSCCT stop smoking practitioner survey 2010 (further information / data can be provided): http://www.ncsct.co.uk/Content/FileManager/ncsct-annual-ssp-survey-2010.pdf</p> <p>2011/12 Statistics on stop smoking services: http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/nhs-stop-smoking-services/statistics-on-nhs-stop-smoking-services--england-april-2011-to-march-2012</p> <p>NCSCCT training: http://www.ncsct.co.uk/training</p> <p>Evaluation of the NCSCCT online training programme which showed an increase in knowledge from initial training needs analysis to final assessment:</p> <p>Brose et al. (in press). Effectiveness of an online knowledge training and assessment programme for Stop Smoking Practitioners. <i>Nicotine & Tobacco Research</i>.doi: 10.1093/ntr/ntr286</p> <p>Evaluation of the NCSCCT face-to-face training courses which showed an increase in confidence in competence following training:</p> <p>Brose, S. L, West, R. Michie, S and McEwen, A (2012). Evaluation of Face-to-Face Courses in Behavioural Support for Stop Smoking Practitioners <i>Journal of</i></p>
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				<p>minimum quality standard.</p>	<p>Smoking Cessation, 7(1) doi 10.1017/jsc.2012.6</p> <p>Reference for greater quit rates amongst full-time versus community stop smoking practitioners:</p> <p>Brose et al. (2011). What makes for an effective stop-smoking service? Thorax, 66(10), 924-926. doi: 10.1136/thoraxjnl-2011-200251</p> <p>Behaviour change techniques for smoking cessation:</p> <p>Michie, S., Churchill, S. & West, R. (2011) Identifying Evidence-Based Competences Required to Deliver Behavioural Support for Smoking Cessation. Annals of Behavioural Medicine, 41:59–70. doi: 10.1007/s12160-010-9235-z</p> <p>DH 2011/12 Local stop smoking service, service and monitoring guidance – see Intervention Quality Principles pg.28 re. NCSCCT certification: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_125389</p>
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9	RCN	<p>The topic overview for this quality standard seems comprehensive.</p> <p>There are no further comments to make at this stage.</p>			
14	NHS Central Lancashire	<p>Tighten up the definition of 'specialist support' in primary care that is used for giving stop smoking advice.</p> <p>Need appropriate pathways for quality services</p>	<p>Interpretation of QOF affects the quality of the service.</p> <p>With limited resources, need to ensure that payments claimed under QOF for providing specialist support for anyone identified as a smoker meet the need. The definition of what specialist support involves should be a lot clearer.</p>	<p>There is a discrepancy between what is needed to get QOF points and what is recommended by NICE guidance in respect of specialist advice given by primary care staff. Primary care staff claim payment under QOF by ticking a box, and there is little quality control about the specialist support that should be provided for people who are identified as smokers.</p> <p>Need to align QOF with NICE recommendations</p>	
31	Pfizer	<p>Pfizer notes that the following commissioning outcomes framework (COF) domain indicators are not currently included within the smoking cessation quality standard topic overview:</p>	<p>It appears that clinical commissioning groups will be evaluated based on their ability to prevent people from dying prematurely by reducing the under 75 mortality rate from cardiovascular disease, respiratory disease, and cancer. One of the key measures for achieving this will be by ensuring that good quality smoking cessation services are commissioned across all regions of England, since smoking is associated with the greatest number of preventable deaths compared to other public health</p>	<p>Fifty-two percent of all smoking attributable deaths in England are due to cardiovascular and respiratory diseases, while cancers account for another 46% of smoking attributable deaths (NHS Information Centre, 2009).</p> <p>While preventing people from starting to smoke will be important to reduce prevalence of CVD, respiratory disease, and cancer over the long-term, getting people to stop smoking will be key to reducing premature deaths due to these</p>	<p>References:</p> <ol style="list-style-type: none"> 1. ASH Factsheet, Smoking Statistics: illness & death, October 2011 (http://ash.org.uk/files/documents/ASH_107.pdf). 2. NHS Information Centre, Statistics on smoking: England 2009 available at www.ic.nhs.uk/webfiles/publications/smoking_09/statistics_on_smoking_england_2009.pdf 3. West R. Shiffman S. S Fast Facts, 2nd Ed. Oxford Health Press, 2007 4. US Department of Health and Human

<p>Cardiovascular domain 1: Preventing people from dying prematurely 1.1 Under 75 mortality rate from cardiovascular disease</p>	<p>priorities such as obesity, alcohol, suicide, traffic accidents and drug misuse (ASH 2011) .</p> <p>However, from 2013 the commissioning of smoking cessation services will be the responsibility of local authorities, and not PCTs. Therefore it is vital for the proposed smoking cessation quality standard to include specific quality indicators for clinical commissioning groups and local authorities that will ensure that they are able to work in partnership to commission effective, good quality smoking cessation services.</p>	<p>diseases in the next 5-10 years. Between 3 and 9 months after quitting smoking lung efficiency is up by 5-10%, and breathing problems are gone (West et al 2007). One year after quitting, excess coronary heart disease risk is half that of a smoker (US Dept of Health, 2004), and 5 years after quitting an ex-smoker has half the chance of a heart attack than a smoker (West et al 2007). In terms of cancer prevalence reduction, the benefits of smoking cessation are longer-term, with lung cancer death rates half that of a smoker and decreased risks of mouth, throat, oesophagus, bladder, kidney and pancreatic cancer 10 years after stopping smoking (US Dept of Health, 2004).</p>	<p>Services. The Health Consequences of Smoking: what it means to you. U.S. Department of Health and Human Services, Centres for Disease Control and Prevention, National Centre for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2004. http://www.cdc.gov/tobacco/data_statistics/sgr/2004/pdfs/whatitmeanstoyou.pdf.</p> <p>5. West R, Brown, J. Smoking and Smoking Cessation in England 2011: Findings from the Smoking Toolkit Study.</p> <p>6. Local Tobacco Control Profiles for England. http://www.lho.org.uk/lho_topics/analytic_tools/TobaccoControlProfiles/default.aspx</p>
<p>Respiratory domain 1: Preventing people from dying prematurely 1.1 Under 75 mortality rate from respiratory disease</p>	<p>However, from 2013 the commissioning of smoking cessation services will be the responsibility of local authorities, and not PCTs. Therefore it is vital for the proposed smoking cessation quality standard to include specific quality indicators for clinical commissioning groups and local authorities that will ensure that they are able to work in partnership to commission effective, good quality smoking cessation services.</p>	<p>In terms of effective smoking cessation interventions, the evidence suggests that NHS support (includes medication) is associated with 3.14 times the odds of quitting compared with unaided quit attempts; use of medication on prescription is associated with 1.67 times the odds of quitting; and NRT bought over the counter does not result in improvement in success rates compared with unaided quit attempts (West 2011). NHS services therefore offer smokers the best chance of quitting smoking.</p>	
<p>Cancer domain 1: Preventing people from dying prematurely 1.1 Under 75 mortality rate from cancer</p>		<p>A smoking cessation quality standard will need to ensure via specific indicators that local authorities work in partnership with clinical commissioning groups to 1)</p>	

				commission effective NHS smoking cessation services, and 2) evaluate annually the quality of the services commissioned via audit in relation to benchmark data (previous annual local smoking indicator data on successful 4-week quit rates, smoking attributable deaths from heart disease, smoking-attributable deaths from stroke, deaths from lung cancer, oral cancer registrations, and deaths from COPD as per the local tobacco control profiles for England http://www.lho.org.uk/lho_topics/analytic_tools/TobaccoControlProfiles/default.aspx	
3 2	Pfizer	Pfizer notes the inclusion of the NICE guidance in development on smoking cessation – acute and maternity services cited in the proposed smoking cessation quality standard topic overview. This will be an important source of guidance to build into the proposed quality standard as it will include recommendations	The smoking cessation quality standard scope should be expanded to cover local authority provision of smoking cessation services. It will be important for local authorities to make provision in their commissioning arrangements to ensure local smoking cessation services are provided for hospital patients.	Smoking cessation prior to surgery is associated with a significant reduction in all surgical complications (Mills, 2010). Other post operative health benefits associated with smoking cessation include: <ul style="list-style-type: none"> • Reduced risk of pulmonary complications such as respiratory failure (Warner 2005). • Acute smoking has been associated with increased ST depression during anesthesia (Woehlck 1999) • Decreased risk of graft failure (Willigendael 2005) • Decreased wound related complications such as dehiscence and infection (Warner 2007) • Increased rate of bone healing (Warner 2006; Haverstock 1998) • Permanent smoking cessation reduces 	References: <ol style="list-style-type: none"> 1. The National Institute for Health and Clinical Excellence (NICE) Commissioning Guide, Implementing NICE guidance. Smoking cessation service for people having elective surgery. April 2009. 2. The National Institute for Health and Clinical Excellence (NICE). Public Health Guidance PH10. Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities. February 2008. 3. Mills E, Eyawo O, Lockhart I, Kelly S, Wu P, Ebbert JO. Am J Med. 2011 Feb;124(2):144-154.e8. 4. Warner DO. Medical Intelligence 2005; 101:481-487. 5. Woehlck HJ, et al. Anesthesia & Analgesia 1999; 89(4):856-860.

<p>on the role of smoking cessation interventions administered in acute hospital settings, including smoking cessation therapy administered prior to surgery. NICE already recommends that patients referred for elective surgery should be encouraged to stop smoking before an operation (NICE PH10, 2008; NICE Commissioning Guide, 2009). The 2009 NICE Commissioning Guide calculated that for an average PCT with a population of 300,000, the average number of people who smoke, have elective surgery and are referred</p>	<p>the risk of premature death (Doll 2004).</p> <p>The evidence indicates that smoking cessation is associated with a number of health benefits for surgery patients, but this evidence is also relevant for hospitals interested in reducing post-operative complications from a resource use perspective. The smoking cessation quality standard should generate quality indicators that 1) ensure hospital trusts and local health authorities work in partnership to commission appropriate smoking cessation services for this group of patients, and 2) ensure these services are audited for quality in respect to benchmark patient outcome data, e.g. annual incidence of surgical complications, and 4 and 12 week quit rates.</p>	<p>6. Willigendael EM et al. Journal of Vascular Surgery 2005; 42(1):67-74. 7. Warner DO. Tobacco control for anesthesiologists. Journal of Anesthesia 2007; 21(2):May. 8. Warner DO. Perioperative abstinence from cigarettes: Physiologic and clinical consequences. Anesthesiology 2006; 104(2):Feb. 9. Haverstock BD, Mandracchia VJ. The journal of foot and ankle surgery 1998; 37(1):69. 10. Doll R, Peto R, Boreham J, Sutherland I. BMJ 2004; 328:1519.</p>
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	<p>to a smoking cessation service would be 1200 per year. While some secondary care institutions have their own in-house smoking cessation service, most patients are referred to a NHS smoking cessation service in primary care. However, responsibility for commissioning primary care smoking cessation services is due to transfer from PCTs to local authorities in 2013. It is not clear whether local authorities will make provision when commissioning local smoking cessation services for treatment of hospital patients.</p>			
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