

A guide to smoking cessation in Scotland 2010

Planning and providing specialist smoking cessation services

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Preface: Terminology and source material

Terminology

Brief interventions

This document uses the following definition of brief interventions taken from two of the key source material documents^{1,2} outlined below.

Brief interventions:

Opportunistic advice, discussion, negotiation or encouragement, and referral to more intensive treatment where appropriate. They are commonly used in many areas of health promotion and are delivered by a range of primary and community care professionals. For smoking cessation, brief interventions typically take between five and ten minutes and may include the following:

- simple opportunistic advice to stop
- an assessment of the patient's commitment to quit
- an offer of pharmacotherapy and/or behavioural support
- provision of self-help material
- referral to more intensive support such as the NHS smoking cessation (stop smoking) services.

Specialist smoking cessation services

These are NHS-supported services that provide an enhanced level of smoking cessation support from that provided through brief interventions, to particular standards, and are staffed by specialists or advisers who have undertaken nationally recognised training to the appropriate national standards. These services provide intensive group and 1:1 support for a series of planned sessions throughout the quit attempt, in conjunction with pharmacotherapy, and follow up the client beyond the quit date. These sessions extend at least as far as the one-month post quit-date follow-up but often throughout the duration of pharmacotherapy use in the quit attempt. The full definition of a specialist service is available in Section 2.3.

The term 'smoking cessation services' tends to be the more frequently used term in Scotland, and is the professionally recognised term among health practitioners and used within the field of smoking cessation and smoking cessation research. Therefore, this is the term adopted most frequently throughout this publication. The term 'stop smoking services' tends to be the commonly recognised term used among members of the public, and is therefore used by health professionals when discussing the services with patients/clients in order to provide a clearer understanding of what they are.

Key source material

Unless otherwise indicated, all recommendations contained within this document draw on (either taken directly, or are adapted or inferred from) one or more of the following evidence-informed resources (which are referred to by number in the text):

1. *NHS Health Scotland Commentary on NICE Public Health Intervention Guidance no.1 – Brief interventions and referral for smoking cessation in primary care and other settings* (NHS Health Scotland, 2007)¹.
2. *NICE Public Health Guidance 10 – Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities* (National Institute for Health and Clinical Excellence, 2008)².
3. *NICE Public Health Guidance 26 – How to stop smoking in pregnancy and following childbirth* (National Institute for Health and Clinical Excellence, 2010)³.
4. *Smoking Cessation Guidelines for Scotland: 2004 Update* (NHS Health Scotland and ASH Scotland, 2005)⁴.
5. *Smoking Cessation Update 2007: Supplement to the 2004 Smoking Cessation Guidelines for Scotland* (NHS Health Scotland and ASH Scotland, 2007)⁵.

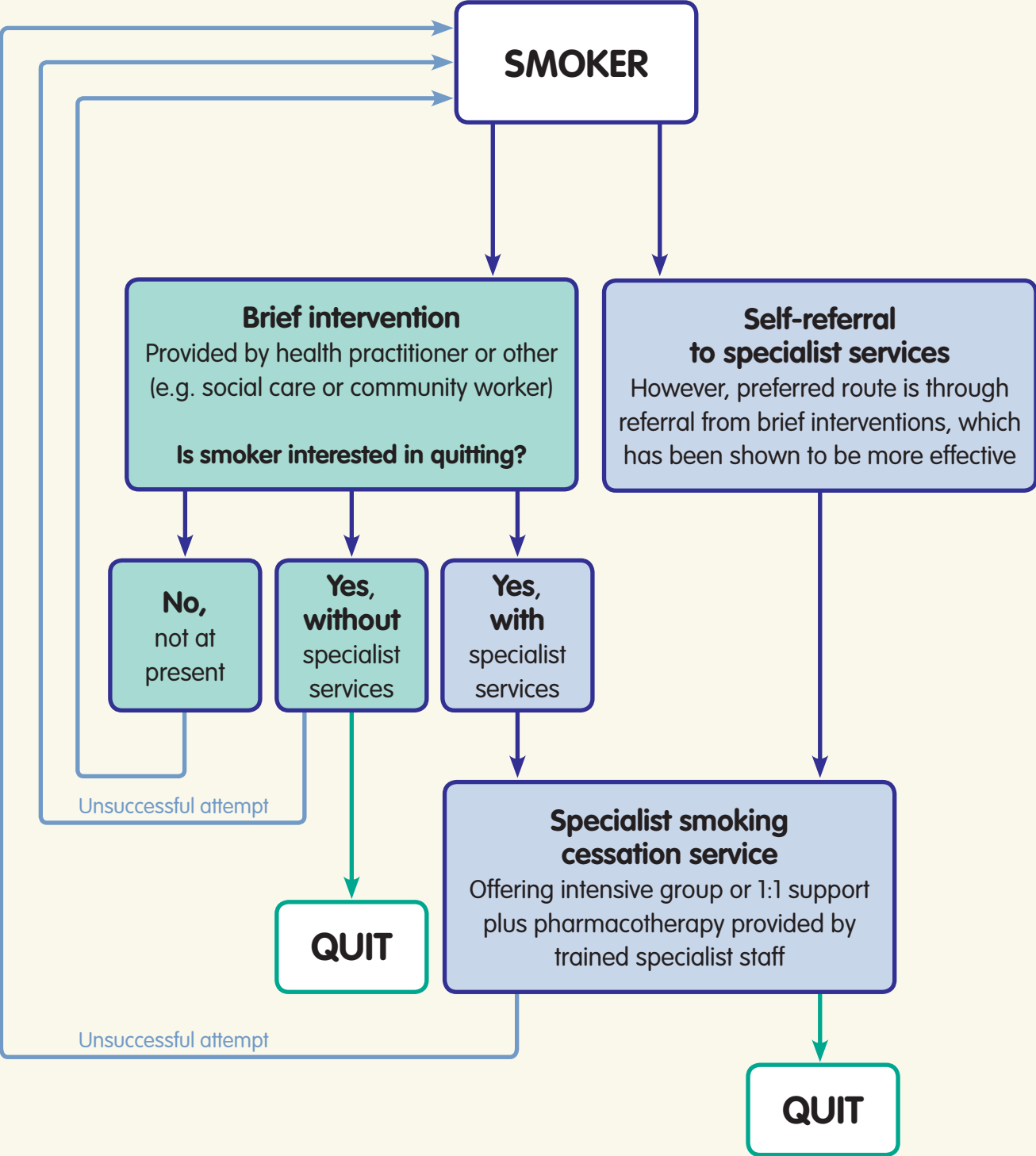
Further details on these sources are available in the Appendix.

In cases where the evidence provided by the above sources was conflicting or unclear, expert advice was sought from smoking cessation and tobacco control academics.

Pathway for smokers quitting through NHS Scotland smoking cessation services

The diagram on page 5 is an illustration of the ways that a current smoker may engage with services, and move on to successfully quit, through contact with both a provider of **brief interventions** (the **green** coloured boxes, and supported by the *Helping smokers to stop* part of the guide and accompanying flowchart) and **specialist interventions** (the **blue** coloured boxes, and supported by this document).

Figure 1: A pathway for smokers quitting through NHS Scotland smoking cessation services



Developed by *A guide to smoking cessation in Scotland 2010* Working Group, 2009

1 Introduction

1.1 Purpose of the guide

1.1.1 The guide as a whole and its audience

The purpose of this guide is to inform NHS policy and practice in smoking cessation by bringing together up-to-date, evidence-informed, advice on helping people to stop smoking.

The guide replaces the 2004 update and 2007 supplement of the *Smoking Cessation Guidelines for Scotland*. It has been developed to summarise multiple source materials in one publication for each of two groups of professionals:

- all health practitioners who are not specialists in smoking cessation, in any branch of health care (a separate document, entitled *Helping smokers to stop*)
- smoking cessation specialists, smoking cessation coordinators and service commissioners (this document).

It is intended for use in Scotland by anyone who can contribute to smoking cessation – whether through the provision of brief interventions, specialist advice, or through policy and service planning. This advice is generally collated from the key sources outlined in the preface and further detailed in the Appendix; these include NICE guidance through which robust quality assurance processes have taken place. The guide is not intended to provide new recommendations over and above those contained in these key sources although it does contain examples of good practice from Scottish experience and elsewhere, which can be used to inform service development.

The guide as a whole comprises two components:

- The component for health and health-related practitioners *Helping smokers to stop*, and its accompanying flowchart, is intended to be read and utilised by a wide range of health (including social care, and other community and voluntary) practitioners – anybody who can contribute to smoking cessation by giving opportunistic advice (this is commonly referred to as ‘brief interventions’ as defined on page 3 in the preface and in Section 2.2 which follows). This could be professional, support or administrative staff in primary or secondary care who should raise the issue of smoking through normal, day-to-day interaction with patients and potentially refer on to services, or GPs who may prescribe pharmacotherapies (pharmaceutical products for smoking cessation) along with brief intervention support (but not to the same level or frequency as specialist support). *Helping smokers to stop* will have a wide audience, and the role brief interventions play in helping smokers in Scotland to quit is illustrated by the **green** boxes in the diagram ‘A pathway for smokers quitting through NHS Scotland smoking cessation services’ on page 5 in the preface.

- The *Planning and providing specialist smoking cessation services* resource (this document) is intended for use in Scotland by those who provide or commission specialist smoking cessation services: Directors of Public Health; commissioners; policy/service planners/managers; directors of services in primary care and acute sectors of the NHS; NHS Board smoking cessation coordinators; smoking cessation specialist advisers or those who provide specialist smoking cessation support funded by the NHS (whether based in the NHS, local authorities, or in the community, voluntary or private sectors); and pharmacists involved in the national pharmacy scheme and therefore who provide smoking cessation support at a more intensive or an enhanced level than brief interventions. The role specialist smoking cessation provision should play in helping smokers in Scotland to quit is illustrated by the bottom blue box in the diagram 'A pathway for smokers quitting through NHS Scotland smoking cessation services' on page 5 in the preface.

1.1.2 *Planning and providing specialist smoking cessation services:* Purpose, audience, intended use, structure and content

The purpose of this component of the guide is to focus on both the planning, provision and delivery of specialist smoking cessation services and to provide NHS Boards with clear and up-to-date evidence-informed advice on smoking cessation interventions and the role of health boards and commissioners in taking this forward at local level. This component is divided into two parts:

Part 1: Providing and delivering: What should a specialist service look like? (Sections 2–6)

Part 2: Commissioning and planning: Specialist smoking cessation services (Sections 7–8)

Part 1: Providing and delivering

This part provides details (covering definitions, recommendations, and the relevant evidence base) on smoking cessation interventions, that anybody involved in service delivery should be familiar with. The evidence for the recommendations here is primarily drawn from the best available and most robust sources. Areas covered include behavioural support, the use of pharmacotherapy, data collection and training standards. Smoking cessation is one part of a multi-disciplinary approach aimed at reducing tobacco-caused harm. (For this reason, this section should be considered in the context of, but will not cover in detail, other aspects of tobacco control such as prevention and education, legislation, economics, and other protection and control measures).

Part 2: Commissioning and planning

This part is primarily concerned with laying out the background, structures, and providing pointers on good practice and operational service issues to consider, for the interest of commissioners and service planners. This section contains 'good practice' examples and recommendations on achieving high quality smoking cessation services. It should be noted that these recommendations and examples differ from those given in **Part 1: Providing and delivering** as a greater proportion (particularly in Section 8) may not necessarily be backed up by as strong or quality assured research evidence. Instead, these examples and recommendations are primarily from the commissioning section within the Department of Health's *NHS Stop Smoking Services Service and Monitoring Guidance* which provides guidance and principles for the delivery and commissioning of services to improve the quality and consistency of support provided. Evidence here is based on previous guidance, an understanding of good practice obtained from service evaluations, and observation of service practice. While the evidence for this section is primarily sourced from observation rather than published research evidence, it still provides useful principles which remain valid when applied to Scotland. The source of these 'good practice' examples is included.

1.2 The context: Where we are and future direction

1.2.1 Since 1999, there have been major developments in smoking cessation and tobacco control in Scotland, including recognition by the Government and Scottish Parliament of the important role that smoking cessation can and should play in improving the health and wellbeing of the population of Scotland.

A continued focus on smoking cessation through investment in smoking cessation services and the creation of targets for smoking cessation has culminated in tens of thousands of smokers making quit attempts across Scotland every year through the smoking cessation services (SCSs) which are in place in every NHS Board in Scotland.

Despite these developments (covered in more detail in Section 7), Scotland continues to have one of the highest smoking rates in Europe, remaining within the top third of a range of European countries for women and within the top half to one-third for men⁶. Tobacco remains the major preventable cause of ill health, disability and premature death in Scotland^{4,7,8,41}, accounting for more than 13,000 smoking-attributable deaths each year⁸ (24% of all deaths^{6,8}), and a considerable reduction in number of years of life expectancy⁹ in others. For every smoker in the US who dies per year from smoking, an additional 20 suffer from smoking-related disease¹⁰.

In the year 2000, the UK and Hungary topped the international cross-country profile table for Europe in terms of countries with the highest percentage of deaths attributable to smoking¹¹. In order to reduce this toll on the nation's health, considerable work must be undertaken by all health and social care practitioners to ensure that everyone makes a contribution, however small, in helping smokers to quit, and that SCSs are supported, consolidated and extended in order to provide as equitable a service as possible and in order to reach those most in need.

1.2.2 People smoke for a variety of reasons and a large number of factors are associated positively or negatively with the ability to quit – the effect of socio-economic, social or life circumstances; personal motivation and degree of dependence on cigarettes; other personal and family factors; existing medical conditions; and pharmacological factors among others^{12,13}. Successful interventions must therefore take into account and address a complex combination of such factors¹³.

1.2.3 Developments in tobacco control which will impact and have impacted on smoking prevalence and smoking cessation, have included:

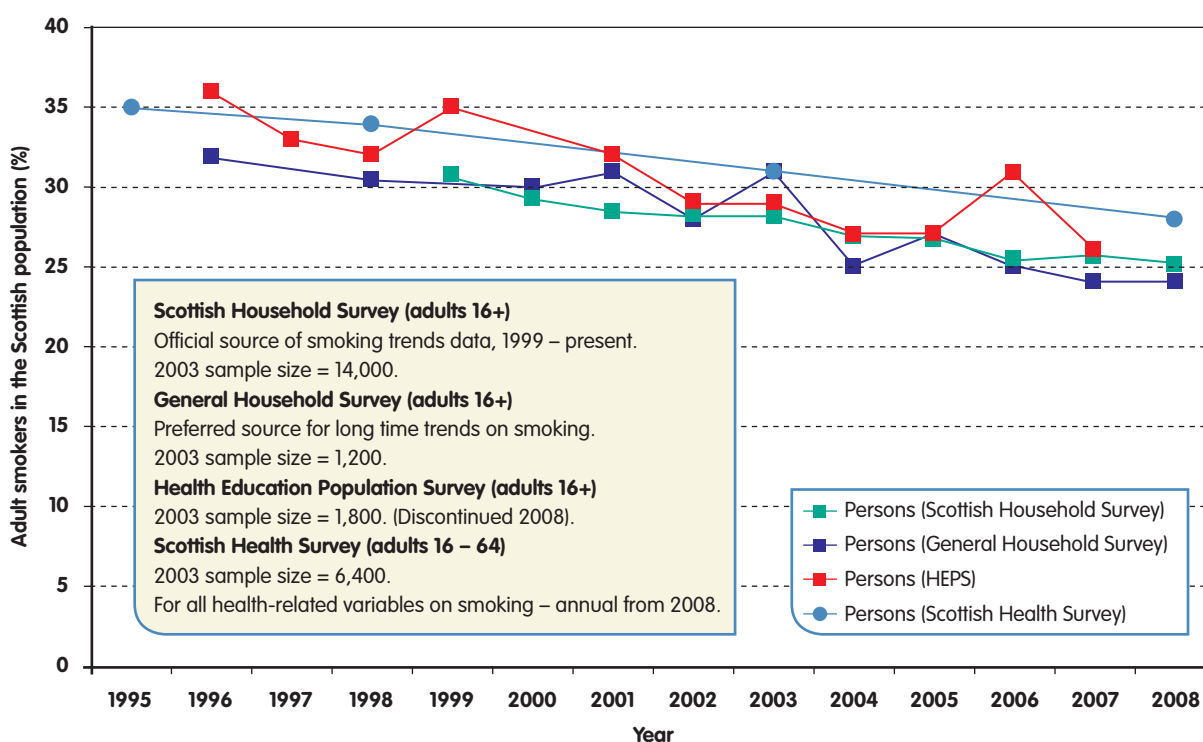
- investment in, and development of, smoking cessation services (SCSs) in Scotland (further detailed in Section 7)
- the upgrade of an existing national tobacco control strategy group to a Ministerial Working Group on Tobacco
- the publication of the Tobacco Control Action Plan, *A Breath of Fresh Air for Scotland* – the overarching tobacco policy document in Scotland which sets out a programme of action for NHS Boards and national organisations to tackle smoking and tobacco-related harm, including a specific action for NHS Boards concerning the provision of SCSs
- the development of Partnership Action on Tobacco and Health (PATH), a joint initiative between ASH Scotland, NHS Health Scotland and the Scottish Government, to reduce the prevalence of tobacco use in Scotland (www.ashscotland.org.uk/ash/3355.html)
- a national programme of eight pilot smoking cessation interventions aimed at young people (evaluation available at www.healthscotland.com/documents/1381.aspx)
- the publication of the Smoking Prevention Action Plan (2008) which focuses specifically on protecting young people from tobacco and preventing them from smoking (available at www.scotland.gov.uk/Publications/2008/05/19144342/0)
- £1.5 million investment in smoking prevention
- multi-media communications campaigns and a range of health education resources have been developed and regularly revised and updated
- legislative action around smoke-free public places and age of sales for tobacco which came into force in March 2006 and October 2007 respectively; a bill that passed through the Scottish Parliament in January 2010 reforms further aspects of tobacco sales law (including prohibiting retail display of tobacco products and banning cigarette vending machines).

1.2.4 What are the current levels of smoking?

Tobacco use can be defined in various ways. Although the most common use of tobacco in Scotland is by smoking manufactured cigarettes, it can also be smoked in hand-rolled cigarettes or pipes, as cigars, or chewed. Forms of non-smoked tobacco can be particularly prevalent amongst some minority ethnic communities, where the use of products such as paan, gutkha, khainini and tombak is significantly more common than in the population as a whole. Prevalence information for wider forms of tobacco use in Scotland is inconsistent due to lack of available information and lack of up-to-date, robust survey evidence, and therefore the following only contains details of cigarette smoking prevalence.

Different surveys use differing techniques and hence can obtain different results. By looking at the overall picture, however, the general trends can be examined and this is the purpose of the graph in Figure 2 which shows adult smoking prevalence trends from four surveys. The rate of decrease has decelerated in recent years, depending on the survey used, but data from all available sources shown below generally shows a consistent downward trend. Between 1972 and 2004, the proportion of Scottish adults aged 16+ smoking daily fell from 47% to 25% (General Household Survey data). The largest Scottish-specific survey (The Scottish Household Survey), which yields the most robust data, shows a similar degree of decline over the last decade, dropping from 30.7% in 1999 to 25.2% in the most recent survey in 2008.

Figure 2: Adult smoking prevalence, Scotland, 1995–2008 updated in 2009 from 6



1.2.5 Local prevalence of smokers has been reported in the following publications:

- *Tobacco Smoking in Scotland: An epidemiology briefing* (NHS Health Scotland/ ScotPHO, February 2008)
www.scotpho.org.uk/home/Publications/scotphoreports/pub_tobaccobriefing.asp
- *Young Adult Smokers in Scotland* (NHS Health Scotland/ScotPHO, December 2008, revised December 2009)
www.scotpho.org.uk/home/Publications/scotphoreports/pub_youngsmokers.asp
- *An Atlas of Tobacco Smoking in Scotland* (NHS Health Scotland, ISD Scotland and ASH Scotland, 2007)
www.scotpho.org.uk/home/Publications/scotphoreports/pub_tobaccoatlas.asp
which estimates smoking prevalence and smoking-attributable deaths within Scotland
- Scottish Health Survey reports and Scottish Household Survey reports (which are used alongside data on Scottish smoking cessation services produced by ISD)

1.2.6 Targets

There are several Scottish targets for smoking prevalence and smoking cessation, the first of which has also been translated into specific targets for NHS Boards:

- **Reduce the prevalence of smoking among adults** (age 16+) in Scotland from 26.5% (2004 baseline) to 22.0% by 2010 – a target reduction of 17.0%. This target appears as a National Indicator in the Scottish Government's National Performance Framework *Scotland Performs* in the form 'reduce the percentage of the adult population who smoke to 22% by 2010'.
- **Reduce the percentage of women who smoke during pregnancy** from 29% (1995 baseline) to 20% by 2010.
- **Reduce the prevalence of regular smoking among 13-year-old girls** (defined as smoking one or more cigarettes per week) from 5% (2006 baseline) to 3% in 2014, and **among 13-year-old boys** from 3% to 2%.
- **Reduce the prevalence of regular smoking among 15-year-old girls** (defined as smoking one or more cigarettes per week) from 18% in 2006 to 14% in 2014, and **among 15-year-old boys** from 12% to 9%.
- **Reduce the prevalence of smoking among 16 to 24-year-olds** (both sexes combined) from 26.5% (2006 baseline) to 22.9% in 2012.
- As one of the HEAT (Health Improvement, Efficiency, Access and Treatment) health improvement performance targets for NHS Scotland (which are set within the National Performance Framework referred to above), each NHS Board should, through smoking cessation services, **support 8% of its population of smokers in successfully quitting** (at one month post-quit) over the period 2008/09 to 2010/11.

In addition, the aforementioned 17% prevalence target reduction was applied separately to each NHS Board's estimated prevalence in 2004 to generate a target number of smokers and prevalence rates for each NHS Board by 2010. Contributions to meeting these local targets as well as the above-mentioned HEAT 6 target are reported on via Local Delivery Plans, and achievement is measured through the annual Scottish Household Survey.

Contributions to each of the targets outlined above, with the exception of the HEAT target which focuses purely on the contribution of SCSs, will be from a range of tobacco control activity, of which SCSs are just one part. This activity will include brief intervention support provision and legislative measures, along with prevention and education.

1.3 Background and context material

1.3.1 As outlined in the preface and detailed further in the Appendix, the evidence for this document is drawn from five key evidence and source materials. These should also be considered alongside other relevant documents for smoking cessation context and service implementation and monitoring, and also in the wider context of relevant Scottish Government health policy publications, listed in the Appendix.

Part 1: Providing and delivering – What should a specialist service look like?

2 Description of specialist smoking cessation services

2.1 Specialist smoking cessation services: Context and roles of staff

The *pathway for smokers quitting through NHS Scotland smoking cessation services* diagram on page 5 shows potential routes that smokers may take on a path to a successful quit. It shows that, regardless of whether the point of entry to the system is from a brief intervention (represented in the diagram by the green coloured boxes) or from a specialist service (represented in the diagram by the blue coloured boxes), the system works towards the same goal and includes communication and referral across the different branches.

Both those providing brief interventions and those providing specialist smoking cessation support have distinct but interdependent roles to play. While this document focuses on the provision of specialist services, it is useful to be aware of, and reflect upon, the wider context in terms of the different routes a smoker may take.

Specialist services and wider smoking cessation activity, such as brief interventions, should be integrated, enabling potential referrers to understand the role of such services better and act as more effective sources of referrals. Non-specialists can contribute to smoking cessation by providing brief intervention support – they have the potential to be a vital source of referrals to the smoking cessation services as well as to trigger unaided quit attempts. Therefore, while intensive behavioural support, as provided by a specialist service, significantly increases the success-rate of any quit attempts made, brief interventions are effective in triggering large volumes of those quit attempts. Although details on brief interventions, and the importance of this role in delivering them, are the focus of the *Helping smokers to stop* component of the guide, they are also summarised briefly below.

2.2 Definition: Brief interventions

2.2.1 The terms 'brief advice' and 'brief intervention' vary in terms of duration and content they refer to, and additionally, are often used interchangeably. However, the term and definition adopted in this guide is from Source 1 (and 2), given that many of the recommendations in the *Helping smokers to stop* component are derived from these sources, and is defined below and on page 3 in the preface.

Opportunistic advice, discussion, negotiation or encouragement, and referral to more intensive treatment where appropriate. These brief interventions are commonly used in many areas of health promotion and are delivered by a range of primary and community care professionals. For smoking cessation, brief interventions typically take between five and ten minutes and may include the following:

- simple opportunistic advice to stop
- an assessment of the patient's commitment to quit
- an offer of pharmacotherapy and/or behavioural support
- provision of self-help material and referral to more intensive support such as the NHS smoking cessation (stop smoking) services.

2.2.2 *The Helping smokers to stop* component contains details of brief interventions and how to provide them, and includes a flowchart on how a model brief intervention should be carried out.

2.3 Definition: Specialist smoking cessation services

2.3.1 Specialist smoking cessation services (SCSs) are specialist services which offer intensive, evidence-based support in line with the definition and recommendations below and recommendations throughout this component of the guide.

A specialist service is an NHS supported service with staff who have nationally recognised training and dedicated time for group and 1:1 support for a series of planned sessions where the client is followed up at one month, three months and one year post quit-date and the data is recorded.

This definition was developed and agreed by the NHS Boards' smoking cessation coordinators/managers group in conjunction with NHS Health Scotland in September 2006, and is intended to reflect services as they are currently set up in Scotland. It is noted that this definition may change over time as services evolve and further evidence becomes available. Indeed, there are regional variations in Scotland's services which are outlined in the case studies throughout this component of the guide.

See www.healthscotland.com/documents/4661.aspx for the 2012 revised definition of specialist/intensive smoking cessation support.

Figure 3: Further explanation of terms used in the definition of a specialist service

Definition	Explanation of terms/rationale
A specialist service is...	A service which is in some way dedicated (which can be for short or longer sessions) provided by specially trained staff.
...an NHS supported service...	This would normally mean funded by the NHS but leaves room for services trained by the NHS or working to the same levels to be included.
...with staff who have nationally recognised training and dedicated time...	Nationally recognised would mean PATH (Partnership Action on Tobacco and Health) modules, local training approved by PATH or Maudsley courses. Training should meet the criteria in 'Guidance for Health Behaviour Change Training' and should reach or be designed to reach national standards in Scotland. Updates should have taken place within the last five years.
...for group and 1:1 support...	Evidence and current guidelines support group work and 1:1 where desirable and because of geographical constraints.
...for a series of planned sessions...	This would normally be a minimum of four, usually around seven, sessions where the first and last would generally last at least 20 minutes. This will exclude opportunistic and brief advice work, but allow expert practitioners (the staff defined above with regards to training and time) to use personal judgement.
...where the client is followed up at one month, three months and one year post quit-date and the data is recorded.	This should include carbon monoxide (CO) validation at one month.

2.3.2 Smoking cessation services vary from region to region. However, what is referred to here as a specialist smoking cessation service must provide intensive support and work to nationally agreed standards. Conversely, the term 'NHS smoking cessation services' assumes that any intensive smoking cessation support provision within an NHS Board area (i) will form part of that NHS Board's smoking cessation services and that (ii) it will be delivered to the same standards as those of the specialist NHS smoking cessation services. This assumption stands, taking into account the regional variations in Scotland's services and current and further developments of services.

3 Recommendations: How an evidence-informed specialist service should operate

The following material, specifically for specialist smoking cessation services, is generated from the best-available evidence identified from the key source materials outlined on page 4 in the preface.

Only methods of cessation support recommended by NICE, and therefore included within this guide, should be delivered by NHS smoking cessation services in Scotland. Other methods (for example, complementary or alternative medicine approaches), that have not been considered by NICE as having sufficient evidence of their efficacy and cost-effectiveness at this point in time, should not be delivered as mainstream services.

3.1 General principles

These general principles should be read in conjunction with the subsequent sections on pharmacotherapy, behavioural support, and on smoking cessation with particular population groups.

3.1.1 Generic key recommendation

The optimal form of support to aid smoking cessation in those who are motivated and want help to quit involves the combination of multi-session, intensive behavioural support (delivered face-to-face in groups or individually, or by telephone), together with pharmacotherapy^{14,15}. That has been, and remains, the reason for placing a strong emphasis, in Scotland, on referral to NHS smoking cessation services.

Available evidence continues to suggest that the most effective smoking cessation approach is a combination of multi-session intensive behavioural support and pharmacotherapy inferred from Key source material, and additional expert advice

3.1.2 Key recommendations: General principles

As a general rule, healthcare professionals should:

- a. advise and encourage all current smokers to quit, and offer them help to do so, unless there are exceptional circumstances (for example, occasionally it might be judged inappropriate to do so because of a presenting medical condition or other personal circumstances)
- b. link their advice to the individual's medical condition, if it is a smoking-related disease that the smoker presents with
- c. offer advice to stop smoking that is sensitive to the individual's preferences, needs and circumstances. Note: There is no evidence that the 'stages of change' model is more effective than any other approach.

3.2 Behavioural support

3.2.1 What is behavioural support?

Specialist smoking cessation services offer face-to-face behavioural support in addition to the pharmacotherapies they may provide to smokers intending to stop. The support can be offered in groups or individually and follows a structured protocol⁴.

While behavioural support is usually provided face-to-face in group or individual (1:1) format, it may be supplemented with proactive telephone support. The purpose of support is to help the client to plan for and set a quit date, to provide encouragement, advice and motivation to quit and stay quit, and to assist the client in coping with cravings and withdrawal symptoms. It also serves to optimise the use of, and compliance with, pharmacotherapy – maximising the client's chance of success. This is best achieved through developing a supportive relationship with the smoker which includes building rapport, showing empathy, and identifying triggers to prevent relapse.

This support involves scheduled multiple sessions in structured format, usually held weekly and starting at least one week pre-quit and continuing for at least four weeks post-quit at a specified time and place^{2,16}. Groups tend to be held weekly over at least six weeks, and often throughout the duration of pharmacotherapy use in the quit attempt, and in line with the recommendations which follow. There is strong evidence for 'closed' group support and 1:1 support. There is currently insufficient evidence to recommend 'open/rolling' group or drop-in support although these methods are currently being researched.

3.2.2 Recommendations for behavioural support

These recommendations should be read in conjunction with the sections on general principles, pharmacotherapy and on smoking cessation with particular population groups.

As a general rule, and in addition to the general principles in 3.1.2, smoking cessation specialists/advisers and the services they offer should:

- a. offer structured face-to-face behavioural support (group and/or 1:1) and pharmacotherapy to smokers who intend to stop
- b. provide behavioural support involving multiple sessions starting at least one week before the target quit date and continuing for at least four weeks afterwards, generally held on a weekly basis
- c. use a structured protocol for the behavioural support to maximise delivery of all aspects of motivational and pharmacotherapy advice
- d. provide behavioural support for smoking cessation in conjunction with pharmacotherapy, only delivered by specialist (specially trained) staff employed for or with dedicated time for this support provision, rather than brief interventions by health professionals as part of routine care (as this is not an effective substitute for intensive smoking cessation support)
- e. offer tailored advice and support, particularly to clients from minority ethnic and disadvantaged groups and to pregnant women and hospital patients.

3.2.3 Supplementary information

Service deliverers have responsibility for delivering smoking cessation services of high quality, in line with both the evidence and with protocols for data confidentiality. They should ensure that all necessary data is collected in line with guidance produced by ISD and PATH (Partnership Action on Tobacco and Health) – see Section 5 – and that they are trained to national standards and receive the support they need to remain up-to-date with national guidance and research developments.

The following are ‘good practice’ suggestions on the actual contents of an intervention¹⁶. Although there is some overlap with recommendations outlined elsewhere in this document, they include finer detail.

Good practice: Roles for service deliverers¹⁶

Quality principles for smoking cessation interventions: Service delivery

Services will vary in the types of intervention they choose to provide and in their approaches to delivery. The quality of services should remain consistent and be supported by a set of clear underlying principles. These include the following:

- prior to treatment, clients should be informed of all available (evidence-based) treatment options both locally and nationally
- interventions should have a clear structure and content, which is communicated to clients and to which clients must commit
- all interventions should be multi-sessional (with structured behavioural support throughout the quit attempt and the offer of approved pharmacotherapy) with a total potential client contact time of at least 1.5 hours (from pre-quit preparation to at least four weeks after quitting); this will ensure effective monitoring, client compliance and ongoing access to medication
- clients should be supported throughout their quit attempt including throughout the duration of the prescribing period (good practice identified through Scottish case studies)
- interventions should offer weekly support for at least the first four weeks post quit-date; appointments should be scheduled when clients are booked into treatment
- there should be a strong emphasis on verifying CO levels at one-month follow-up (as specified in Section 5.3)
- smoking cessation advisers should show empathy for their clients and adopt a motivational approach, in line with that advocated in training.

Delivery: all interventions should:

- reinforce the motivation to quit and set a quit date
- inform client expectations regarding the structure and process of the intervention
- assess nicotine dependence and offer appropriate feedback
- provide information on the nature of tobacco withdrawal and advice on the management of withdrawal symptoms
- give comprehensive advice on appropriate pharmacotherapies, possible side effects and methods of access
- monitor pharmacotherapy use
- build a repertoire of coping strategies
- include regular carbon monoxide (CO) checks and give feedback on progress
- troubleshoot specific client problems
- plan ongoing coping mechanisms, support and pharmacotherapy at the end of treatment
- assess client satisfaction with the intervention provided.

Further information: Information and literature for clients – Health education resources

Contact number for Smokeline: 0800 84 84 84

LanguageLine facility is available through this service for clients whose first language is not English.

Limited quantities of literature for clients, such as *How to stop smoking and stay stopped*, can be obtained from the local NHS Board area's health promotion and resource library.

Can Stop Smoking website: www.canstopsmoking.com

ASH Scotland Information Service's free enquiry service: enquiries@ashscotland.org.uk

3.3 Pharmacotherapy

3.3.1 Definition

Pharmacotherapy in the context of smoking cessation refers to nicotine replacement therapy (NRT), bupropion (Zyban) or varenicline (Champix) to help reduce the severity of physiological and psychological symptoms experienced by individuals quitting smoking. They help to reduce cravings and withdrawal symptoms.

This section is not an exhaustive guide on modes of action, prescription, individual product guidance or detailed product safety issues, but rather an overview and includes signposts in the direction of suitable sources from where current and more detailed information on these products can be obtained.

Nicotine replacement therapy (NRT)

This contains nicotine, and delivers nicotine to the body, but in smaller quantities than involved in smoking and without exposure to 4,000 other chemicals, including identified carcinogens. There are currently six formats: patch, lozenge, sublingual tablet/microtab, gum, inhalator and nasal spray.

Bupropion

Bupropion hydrochloride (trade name Zyban) was originally developed as an anti-depressant but is licensed in the UK only for smoking cessation. It does not contain nicotine and the way it helps smokers stop is not fully understood. It has multiple actions in the brain involving dopamine and noradrenaline pathways and may also act as a nicotinic antagonist.

Varenicline

Varenicline (trade name Champix) does not contain nicotine and is a partial agonist designed to act primarily on the nicotinic acetylcholine receptor composed of alpha4beta2 sub-units. Its binding alleviates symptoms of craving and withdrawal, and reduces the rewarding and reinforcing effects of smoking by preventing nicotine binding to the $\alpha 4\beta 2$ receptors.

3.3.2 General principles of pharmacotherapy and recommendations

This section should be read in conjunction with the sections on general principles (Section 3.1), sections on smoking cessation with particular population groups (Section 4) which refer to pharmacotherapy, and with the behavioural support section (Section 3.2) of this component of the guide.

Pharmacotherapies can have a variety of side effects in some individuals, but the prescriber should always balance the well-documented short- and long-term risks of continuing smoking against the potential benefits and risks of the pharmacotherapy being considered.

Recommendations for pharmacotherapy

- a. NRT, varenicline or bupropion should normally be prescribed in conjunction with the setting of a quit date and as part of an 'abstinent-contingent' treatment, in which the smoker makes a commitment to stop smoking on or before a particular date (their target quit date).
- b. Some types of NRT products are licensed for use in circumstances where smokers wish to 'cut down to quit'. However, a nicotine-assisted reduction to stop (NARS) strategy should only be adopted if it is part of a properly designed and conducted research study. Participants in any such study should include those who have repeatedly tried – and failed – to quit and those who are adamant that they do not want to quit abruptly.
- c. A prescription of NRT, varenicline or bupropion should be sufficient to last only until two weeks after the target quit date. Normally, this will be after two weeks of NRT, and three–four weeks for varenicline or bupropion, to allow for the different methods of administration and mode of action. Subsequent prescriptions should be given only on an abstinent-contingent basis, i.e. to people who have demonstrated, on reassessment, that their quit attempt is continuing. If a smoker's attempt to quit is unsuccessful using NRT, varenicline or bupropion, a repeat prescription should not be offered within six months unless identified, specific circumstances have hampered the person's initial attempt to stop smoking, when it may be reasonable to try again sooner.
- d. Bupropion is a prescription-only drug which was licensed for use in the UK for smoking cessation with motivational support, in those aged 18 years and over. Varenicline, another prescription-only medication, was accepted for use by the Scottish Medicines Consortium (SMC) for use within NHS Scotland for smoking cessation in those aged 18 years and over, only as a component of a smoking cessation programme. Although subsequent NICE guidance does advise that these products, and NRT, can be prescribed with brief intervention support, the evidence is strongly in favour of their prescription in conjunction with intensive support such as that offered through a specialist smoking cessation service.
- e. Neither varenicline nor bupropion should be used by young people under 18, or by pregnant or breastfeeding women.
- f. Varenicline or bupropion may be offered to people with unstable cardiovascular disorders, subject to clinical judgement.
- g. If prescription or provision of NRT is being considered with young people aged from 12 to 17, pregnant or breastfeeding women, or people who have unstable cardiovascular disorders, the risks and benefits should be explained. To maximise the benefits of NRT, people in these groups should also be strongly encouraged to use specialised behavioural support in their quit attempt. This guidance follows a review by the Committee on Safety of Medicines for the Medicines and Healthcare Products Regulatory Agency (MHRA) in 2005 in which the licence was expanded to include these groups.

- h. Consideration may be given to offering a combination of nicotine patches and another form of NRT (such as gum, inhalator, lozenge, sublingual tablet 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.
- i. Although different types of NRT may be given in combination (e.g. nicotine patches and another form such as gum, inhalator, lozenge, sublingual tablet or nasal spray) as per recommendation 'h' above, only one single type of pharmacotherapy should be used at one time – NRT, varenicline or bupropion should not be used in combination.
- j. Unless there are contraindications or cautions, one medication should not be favoured over another. When deciding which therapies to use and in which order, the options should be discussed with the client or patient to arrive at a choice that is most likely to succeed, taking account of the fact that referral to the NHS smoking cessation service has been made and:
- contraindications and the potential for adverse effects (note: practitioners and prescribers need to maintain an up-to-date knowledge and awareness of any medical conditions and potential for drug interactions in connection with the pharmacotherapies, and refer to the GP if/as appropriate)
 - the client's personal preferences
 - the availability of appropriate behavioural support
 - the likelihood that the client will follow the course of treatment
 - the client's previous experience of smoking cessation aids.

3.3.3 Information sources

The UK Medicines and Healthcare products Regulatory Agency (MHRA)

www.mhra.gov.uk

The MHRA provides information on pharmacotherapies licensed for use in the UK including that provided by the Committee on Safety of Medicines. It also monitors safety of new drugs, and provides updates on new side effects, contraindications or drug interactions. Searching for 'stop smoking' through the website address above will yield information on smoking cessation treatments.

The British National Formulary (BNF)

www.bnf.org

The BNF, which is updated regularly, is intended to provide UK health practitioners with practical information on the selection and clinical use of medicines. A search for 'cigarette smoking' will produce the relevant sections.

The Electronic Medicines Compendium (eMC)

www.emc.medicines.org.uk

The eMC contains updated and accessible information about medicines licensed for use in the UK. It provides both summaries of products and patient information leaflets.

Scottish Medicines Consortium (SMC)

www.scottishmedicines.org.uk

The SMC considers new pharmacotherapies' potential for use in Scotland.

Local Area Drugs and Therapeutics Committees, local formularies and prescribing protocols

These should reflect the above recommendations, guidance and updates, including that from the other sources of information given here, and may be developed and adapted to enable innovative, flexible dispensing practices such as weekly dispensing.

3.3.4 Supplementary information

Further information: What are the pharmacotherapy products?

Nicotine replacement therapy (NRT)

There are six formats of NRT products and all have similar effectiveness. Thus the choice between them for the client/patient can often be one of personal and practical preference, for example:

Patch – discreet and easiest to use.

Gum – allows good control of nicotine dose.

Spray – reportedly good for very addicted smokers due to fast delivery of nicotine.

Sublingual tablet – discreet, flexible, good dose control.

Lozenge – discreet, flexible, good dose control.

Inhalator – good if smoker misses the ritual of smoking.

Regardless of the type used, normal practice is for the client to start using it on the quit date and to continue use for approximately 12 weeks, although this will vary according to manufacturer/brand, format and stage in the quitting process.

The most common combinations are of an acute dosing form (such as the nasal spray or the inhalator) with the patch. It is recommended to prescribe NRT for only two weeks in the first instance, with a second or subsequent prescription(s) offered only if the smoker demonstrates their quit attempt is continuing.

Bupropion (Zyban) is a prescription-only medicine. It comes as a tablet. It has been shown to approximately double a smoker's chance of stopping. If used, it is recommended to prescribe bupropion (Zyban) for four weeks and then a further four weeks if the quit attempt is continuing, with a typical course lasting seven–eight weeks, and starting with a smaller dose one–two weeks prior to the quit date.

Varenicline (Champix) is a prescription-only medicine. It comes as a tablet. It has been specifically developed to help people quit smoking. It is started one–two weeks before a person's target date for stopping smoking. The dose is built up over the first week and the standard course of treatment is 12 weeks. Treatment may be repeated in people who manage to stop smoking, to reduce the risk of relapse, although the benefits seem to be relatively small.

Good practice: Prescribing

NHS Boards should agree a dual therapy prescribing protocol for nicotine replacement therapy (NRT) for use in specialist smoking cessation services and by pharmacists for prescribing more than one NRT product at a time.

NHS Boards smoking cessation coordinators/managers group should review current practice and agree a national protocol on prescribing, and submit this to Area Pharmacy and Therapeutics Committees for approval, in order to encourage consistency across Scotland.

Prescriptions could be written as 'dispense weekly' in order to minimise wastage and improve contact with a healthcare provider for support when collecting prescriptions.

Case studies: Pharmacotherapy

NHS Greater Glasgow and Clyde's service for hospital inpatients uses an inpatient protocol, designed for their acute sector smoking cessation advisers who are not nurses, which details how to request NRT for patients. A standard NRT request form is used internally for hospital pharmacists and one externally through which additional supplies are accessed by patients on discharge from hospital via their local pharmacist. Housebound patients identified by intensive smoking cessation services are issued with an NRT request form, requesting that NRT be issued under the community pharmacy unscheduled care prescription form system (CPUS) given that patients cannot attend their local pharmacy. This policy of pharmacy supply of NRT is to reduce the need for patients to attend GPs to obtain NRT and ensures that CO monitoring is also undertaken.

NHS Grampian ensures that the smoking cessation service – known as the Smoking Advice Service – liaises with GPs for prescribing pharmacotherapies, in particular varenicline.

NHS Lanarkshire has a patient group direction (PGD) for the provision of nicotine replacement therapy products within community-based smoking cessation services. This PGD allows NRT to be offered free of charge within all smoking cessation service clinics. This 'one stop shop' approach means clients can get both behavioural support and pharmacotherapy within the clinic setting from nurse advisers with no need to attend their GP or pharmacy.

3.4 Evidence for intensive interventions offered by specialist smoking cessation services

Evidence-based interventions generally refer to interventions which have been found to be effective in systematic reviews of randomised trials which have robust, rigorous and within-study comparisons between intervention and control groups, and that measure abstinence outcomes at six months (or ideally 12 months), and/or, more importantly, which have been through a robust and rigorous quality assurance process during the production of NICE guidance for smoking cessation.

The following components of specialist smoking cessation services have been approved by NICE as being effective: individual behavioural support, group support, pharmacotherapies.

3.4.1 General evidence of service efficacy

This section, primarily derived from West's review (2008)¹⁴ to update the evidence published by West *et al* in Thorax (2000) *Smoking Cessation Guidelines for Health Professionals: An Update*¹⁷, focuses on comparing side-by-side a range of interventions, and components of interventions, offered by specialist smoking cessation services. Some of the substantiations were based on systematic reviews which have subsequently been updated; however, the most up-to-date reviews have been cited elsewhere in the text, and the conclusions of the updates do not differ substantially.

Figure 4 provides an overview of the individual components of these interventions plus the relative evidence of effectiveness. These estimates are based on Cochrane reviews of randomised trials supplemented with individual studies from other reviews. The figures in the table refer to six-month cessation figures, but longer term studies suggest that only about half of those who have quit at six months can be expected to become permanent non-smokers.

Figure 4: Effectiveness of smoking cessation interventions at six months post-quit^{adapted from 14}

Intervention	Population	6-month abstinence and NNT (number needed to treat)	Control	Review authors
Brief, opportunistic advice from health professional	Unselected smokers attending a consultation for some other condition	Increased 1–3% over baseline quit rate of 3%* NNT = 33–100	-v- doing nothing	Cochrane Database of Systematic Reviews: Lancaster and Stead (2005)
Behavioural support (1:1 or group)	Smokers seeking help with stopping	Increased 3–7% NNT = 14–33 Adding sessions of telephone support: increases six-month continuous abstinence rates by 2–3%. NNT = 33–50	-v- 5% quit rate for people trying to quit but not receiving face-to-face support except brief advice and written materials.	Cochrane Database of Systematic Reviews: Lancaster and Stead (2005); Stead, Perera and Lancaster (2006); Stead and Lancaster (2005)
NRT	15+ per day smokers	Increased 5–8% NNT = 13–20	-v- placebo group quit rates of 8–12%	Cochrane Database of Systematic Reviews: Silagy, Lancaster, Stead <i>et al</i> (2004)
Combined NRT (e.g. patch plus gum)	15+ per day smokers	Increased 1–6% NNT = 17–100	-v- single form of NRT	Cochrane Database of Systematic Reviews: Silagy, Lancaster, Stead <i>et al</i> (2004)
Bupropion	15+ per day smokers	Increased 6–10% NNT = 10–17	-v- placebo quit rates of 10%	Cochrane Database of Systematic Reviews: Hughes, Stead and Lancaster (2007)
Varenicline	15+ per day smokers	Increased 19–20% NNT = 5–11 Increased 3–10% NNT = 8–33	-v- placebo quit rate of 8% -v- bupropion quit rate of 14%	Cochrane Database of Systematic Reviews: Cahill, Stead and Lancaster (2007)

*Increased 1–3% over the spontaneous, unassisted annual quit rate of 3% among regular smokers.

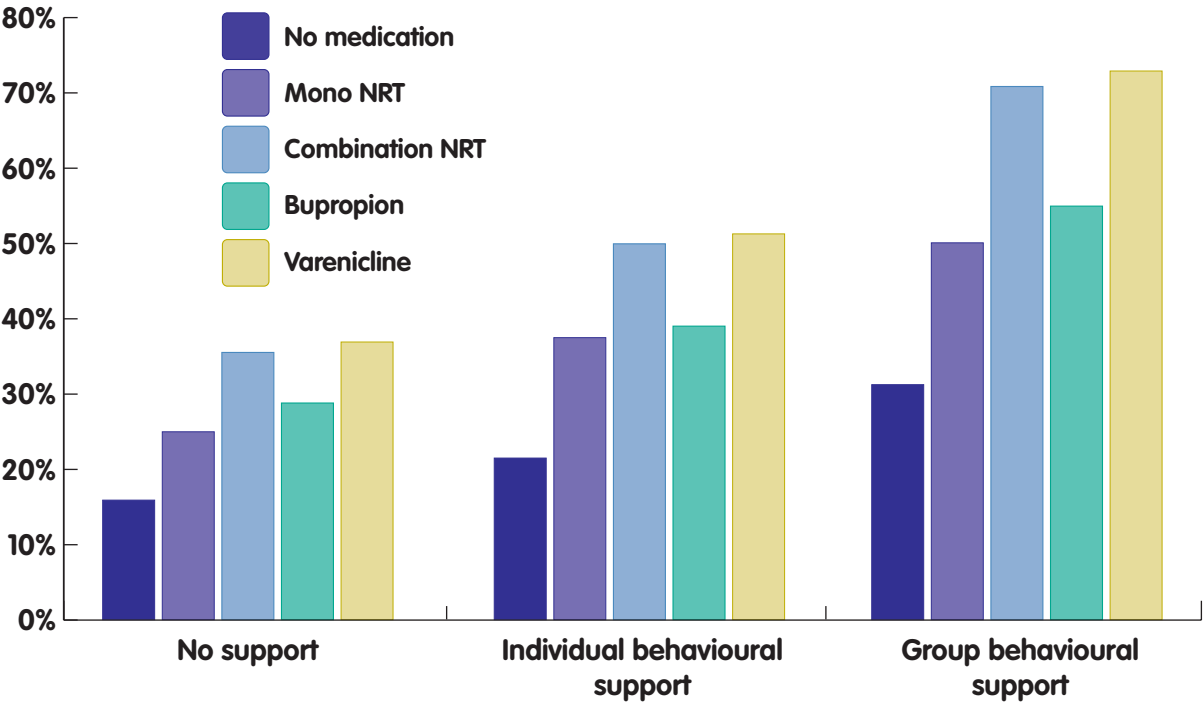
The optimal form of support, referred to previously in this section involving multi-session, intensive behavioural support (delivered face-to-face in groups or individually, or by telephone), together with pharmacotherapy, helps between one in seven and one in ten smokers to stay quit for six months or longer, taking into account context and potential population¹⁴.

Although many practitioners would wish to see success with any treatment to be on a par with the rates of treating infections with antibiotics, or common surgical procedures, smoking cessation measures cannot reward the adviser to the same degree by providing such high success rates. However, robust evidence finds that intensive smoking cessation support (in conjunction with pharmacotherapy) provides the best possible chances of long-term successful quit outcomes. In terms of health gain, successful quits are always worthwhile.

Figure 5 illustrates the approximate percentage of quit attempts achieving one-month quit rates as a function of treatment and therefore the relative impact of various interventions.

Figure 5: Impact of smoking cessation interventions on one-month quit rates¹⁸⁻²²

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



Source: *Cochrane Database of Systematic Reviews*

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

Figure 6 illustrates longer-term quit rates, showing that a combination of pharmacotherapy and behavioural support can result in an increase in abstinence of 10–20% at six months, or 5–10% in permanent abstinence, in comparison with unaided cessation.

Figure 6: Effectiveness of treatments for smoking cessation^{adapted from 25}

Treatment	Comparison	Increase in those abstinent for six months (%)	Increase in permanent abstinence as a result of treatment (%)
NRT all forms 8–12 weeks			
Without behavioural support	Placebo	5	2.5
With behavioural support	Placebo with behavioural support	10	5
Drug with behavioural support			
Bupropion 300 mg 8 weeks	Placebo with behavioural support	10	5
Varenicline 1.5 mg 12 weeks	Placebo with behavioural support	15	7.5
Behavioural support 4–8 weeks			
Face-to-face from specialist	Brief advice or written materials	5	2.5
Telephone-based	Brief advice or written materials	5	2.5
Combination of behavioural support and medication	Quitting without help	10–20	5–10

3.4.2 Cost-effectiveness of smoking cessation services

As the harm caused by continued smoking is so great, smoking cessation interventions (whether brief interventions, group or individual intensive interventions, or pharmacotherapies) are among the most cost-effective interventions available in preserving life²⁶, particularly so relative to other routinely used primary prevention and screening interventions. Smoking cessation remains cost-effective even if an individual has been a smoker for many years. A treatment tends to be recommended to the NHS by NICE if it costs less than £20,000–£30,000 per life year gained (LYG). Statins cost almost £25,000 per LYG; behavioural support and pharmacotherapy costs approximately £1,000 or less per LYG²⁷.

In fact, all of the interventions described above lead to a reduction in the number of smokers, fewer co-morbidities and more quality-adjusted life years compared with no intervention²⁸. In all but one type of smoking cessation provision (that of brief advice plus self-help material plus nicotine replacement therapy provision), smoking cessation interventions are cheaper than doing nothing^{2,28}. Although all smoking cessation interventions are cost-effective, those which are especially cost-effective include group support (over individual support), brief interventions or behavioural support when combined with pharmacotherapy (over either of these without pharmacotherapy, or over pharmacotherapy without either type of support respectively), and varenicline (over other types of pharmacotherapy on its own or placebo)². Specific information on cost-effectiveness of interventions, including those of individual pharmacotherapies, is available from NICE (www.nice.org.uk), including health economic appraisals which emphasise the high cost-effectiveness of smoking cessation interventions²⁸ and that the cost per life year saved is well below the NICE benchmark^{27,29}.

A recent study using previously collected data estimated the number of life years saved through the provision of interventions for every 100,000 smokers. This found that for using only pharmacotherapy, 3,750 discounted life years would be saved, but that using behavioural support and medication would save 7,500–15,000 discounted life years, i.e. taking into account that life years are typically saved several decades later³⁰.

3.4.3 Evidence for behavioural support in specialist interventions

Figures 4–6 provide detail of the effectiveness of various forms of behavioural support, both alone and with pharmacotherapy support included with various control group conditions.

Behavioural support is found to be effective if delivered by specially trained providers; there is no clear evidence of the effectiveness of specialist support when provided by individuals who have not been specially trained or who are mainly employed on other duties⁴.

A Cochrane review of one-to-one support, involving one or more face-to-face sessions, each of more than ten minutes' duration and separate from medical care, with most including further telephone contact for support, concluded that individual support was effective in helping smokers quit, but there was not enough data, as yet, to determine the optimal number of sessions (or the ideal level of 'intensity') of the intervention³¹.

A Cochrane review of group support²¹ concluded that:

- there is not enough evidence to support the use of any specific psychological components in a programme of intervention beyond normal support and skills training
- group therapy is more effective than less intensive interventions (such as being given self-help material without face-to-face contact, or no intervention), and the chances of quitting are approximately doubled.

In terms of comparisons between group versus 1:1 support, the review²¹ concluded that:

- the evidence is currently unclear on whether or not groups are better than individual support, but both are more effective than no treatment or support.

In a rapid review of the evidence for the development of NICE public health guidance 10⁶³, two studies were referred to which found that group interventions may produce higher CO-validated quit rates at four weeks than 1:1 interventions. However, it also recognised that 1:1 interventions are also effective, that many clients have a strong preference for 1:1 support, and that group support is unfeasible in some contexts (e.g. rural areas). Therefore, it is important to offer both 1:1 and group interventions in order to provide choice.

Pro-active telephone support has also been found to be effective¹⁹, especially multiple session support²³, hence it is a feasible practical option to supplement other forms of support, particularly in rural and remote areas. However, given that the benefits of face-to-face behavioural support are well established (and additionally such an approach allows carbon monoxide monitoring to take place), face-to-face support should be offered wherever practicable.

Figure 7: Estimated success rate ranges for different behavioural support intervention types

The following table¹⁶ focuses on different types of behavioural support including different types of group and 1:1 support, and shows that the forms of behavioural support advocated by NICE (1:1, closed group support and/or telephone support) are those for which there is evidence.

Intervention type	Estimated four-week success rate range
One-to-one support	22%–52% ^a
Couple/family support	Insufficient evidence ^b
Closed group support	32%–74% ^a
Open (rolling) group support	Insufficient evidence ^b
Drop-in support	Insufficient evidence ^b
Telephone support	22%–51% ^a
Online support	28%–66% ^c

Notes:

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

3.4.4 Evidence of efficacy: Pharmacotherapy

Figure 4 shows by how much multiple randomised controlled trials (RCTs) have demonstrated the increase in six-month quit rates in comparison with the control or placebo groups, while Figure 6 demonstrates the combined effect of behavioural support with pharmacotherapy.

3.5 Summary of recommendations

Those providing specialist smoking cessation support (e.g. specialist smoking cessation advisers, pharmacists providing support to the national pharmacy scheme standards, those trained to provide intensive smoking cessation support), whether in the NHS, local authorities or the community/voluntary/private sectors, should ensure each of the following:

- the advice provided is sensitive to the individual's preferences, needs and circumstances.

Specifically, they should offer smokers who intend to stop each of the following:

- structured face-to-face behavioural support (group and/or 1:1) involving:
 - multiple sessions starting at least one week before the target quit date and continuing for at least four weeks afterwards, generally held on a weekly basis
 - a structured protocol to maximise delivery of all aspects of motivational and pharmaceutical advice
- pharmacotherapy.

Prescribers, and/or those providing specialist smoking cessation support (e.g. specialist smoking cessation advisers, and those trained to provide intensive smoking cessation support), whether in the NHS, local authorities or the community/voluntary/private sector, should:

- prescribe pharmacotherapy ordinarily only as part of an 'abstinent-contingent' treatment, in which the smoker has made a commitment to stop smoking on or before a particular target quit date
- not prescribe NRT as 'cut down to quit' unless it is part of a properly designed and conducted research study
- not prescribe varenicline or bupropion to young people under 18, or to pregnant or breastfeeding women
- only prescribe one single type of pharmacotherapy at a time – NRT, varenicline or bupropion should not be used in combination (although different formats of NRT may be used in combination by those showing a high level of dependence on nicotine or who have found single forms of NRT inadequate in the past)

- not favour one type of medication over another unless there are contraindications or cautions
- discuss the options with the client or patient in order to make a choice of pharmacotherapy and in which order, taking account of a number of key issues.

Specifically, they should:

- issue the initial prescription for NRT, varenicline or bupropion to last only until two weeks after the target quit date
- only provide subsequent prescriptions on an 'abstinent-contingent' basis, i.e. to people who have demonstrated, on reassessment, that their quit attempt is continuing.

When prescribing or providing, or considering prescribing or providing, NRT to young people aged 12 to 17, pregnant or breastfeeding women, or people who have unstable cardiovascular disorders:

- explain the risks and benefits of NRT use in detail within these particular groups
- strongly encourage these groups to use specialised behavioural support in their quit attempt to maximise the benefits of NRT.

If a smoker's attempt to quit is unsuccessful using NRT, varenicline or bupropion, prescribers/specialist smoking cessation advisers should:

- not offer a repeat prescription within six months (unless identified, specific circumstances have hampered the person's initial attempt to stop smoking, in which case it may be reasonable to try again sooner).

4 Key target groups and other priority population groups

4.1 Target groups and other priority groups

While the general principles and underlying assumptions are that healthcare professionals should advise and encourage **all** smokers to quit, offer them help to do so and refer them to the most effective support available, there are national target groups and other priority groups within smoking cessation for whom specific recommendations and guidance are detailed in this section.

The Tobacco White Paper *Smoking Kills*, the UK's first tobacco policy document, identified three target groups for smoking cessation and reducing smoking prevalence, reiterated in the current overarching policy document *A Breath of Fresh Air for Scotland* and reflected in prevalence targets set. These are:

- socio-economically deprived groups
- young people
- pregnant women.

In addition to the three target groups, there are other priority groups for whom smoking prevalence is high, and/or with particular smoking-attributed or smoking-exacerbated medical conditions.

This section of the document will first describe the three target groups (4.2), and then proceed to describe a (non-exhaustive) list of priority groups (4.3) which services may wish to consider.

The following subsections should be read in conjunction with the section on general principles of smoking cessation support and with the section on pharmacotherapy.

4.2 Recommendations for working with target groups

Generic recommendation for working with target groups

Tailored advice and support should be offered. This may include tailoring to needs, circumstances and preferences, at locations and schedules to suit, within reason and/or where feasible.

4.2.1 Socio-economically disadvantaged individuals and communities

This term 'socio-economically disadvantaged' has been used interchangeably in the smoking cessation field in Scotland with 'deprived groups' and 'low income smokers'. However, the definition can vary e.g. depending on the survey used to measure it. The current measurement – the Scottish Index of Multiple Deprivation (SIMD) – is a measure of relative deprivation based on a large number of individual area indicators such as income, education, and crime. All measures of deprivation by area have advantages and disadvantages as not all deprived people live in 'deprived areas' and not all people living in a 'deprived area' are deprived. However, these measures can still provide a base point for planning services that act to reduce health inequality.

Smoking is still the biggest cause of premature death in Scotland, especially in disadvantaged communities³³, and in the period 2000–04, almost a third (32%) of deaths in the most deprived quintile of Scotland were attributed to smoking, compared with 15% in the least deprived quintile³⁴. A large scale study of a Scottish cohort showed that 'never smokers' had much better survival rates than smokers in all social positions – smoking had a greater influence on mortality than social position⁹. Hence, the scope for reducing health inequalities is limited unless smoking rates can be effectively addressed in disadvantaged communities. Given that social inequalities in tobacco use are a significant contributor to health inequalities, interventions which target and/or are effective in reducing smoking prevalence among deprived groups are likely to promote health equity and 'reduce health inequalities more than any other public health measure'².

Smoking cessation interventions tailored for people from disadvantaged groups may be slightly more effective than generic interventions aimed at this group².

Recommendations for working with socio-economically disadvantaged groups

- a. Services should provide tailored advice and support, particularly to clients from disadvantaged groups.
- b. Services should be easily accessible to this target group and they should be encouraged to use them.

Supplementary information

Good practice: Working with socio-economically disadvantaged groups

In widely scattered rural communities, where deprivation may be dispersed, this may have implications for service delivery and design e.g. it can be more appropriate to target deprived groups and individuals through other routes and characteristics besides that of geographical area.

NHS smoking cessation services in Scotland provide targeted support for socio-economically disadvantaged communities through a variety of means – e.g. locating smoking cessation group sessions in community venues in areas of socio-economic disadvantage. In addition, there has been targeted support for socio-economically disadvantaged communities through Keep Well anticipatory care pilot projects, local tobacco alliances, and national pilot smoking cessation projects funded by ASH Scotland and PATH. These projects have been well-documented, and more information can be obtained by contacting the relevant organisations.

An analysis of the effectiveness of Scottish smoking cessation services³⁵ highlighted that Scottish services have been successful in targeting deprived communities. Although the successful quit rates within deprived populations have been lower than the population average, the higher volume of quit attempts has resulted in greater absolute numbers of successful quits.

4.2.2 Young people showing strong commitment to quit

The greatest health gains are achieved by young people stopping smoking before the onset of smoking-related conditions⁴⁴.

Prevalence targets for young people were revised in 2008's *Smoking Prevention Action Plan*³⁶ and targets for reducing prevalence amongst young people have been highlighted previously (1.2.6). Recommendation 51 in *Equally Well*³⁷ is that it 'should be a key priority within the Government's smoking strategy that NHS Boards and their local partners act to prevent young people in deprived communities from smoking, and to provide more effective support to smokers in those communities to quit.'

Young people are not a homogenous population; some subgroups of young people have particularly high smoking prevalence. Smoking prevalence among looked-after children in Scotland³⁸ aged 11–17 was 44%. Specifically for those 11–17 year-olds living in residential care, the prevalence was 56%. This definition, however, is based on a looser definition of smoking to that used in the SALSUS (*Scottish Schools Adolescent Lifestyle and Substance Use Survey*) and therefore the targets outlined in Section 1.2.6.

A comprehensively evaluated national pilot programme³⁹ did not reach a clear conclusion on whether a specialised youth smoking cessation service should be in place, or what constituted 'best practice' for this target group. However, it did identify learning points such as the importance of the programme being both flexible and structured; based on 1:1 or group support; addressing broader aspects of mental health and wellbeing; and delivered by a service provider young people could trust rather than a stranger.

In a review of programmes⁴⁰ to help young people to quit, complex programmes (including those tailored to the young person's preparation for quitting) and behavioural therapy programmes showed some promise but there was insufficient evidence from the number of trials and participants to judge the efficacy of pharmacotherapies.

As the evidence of what is effective in working with young people is still emerging^{24,32}, a combination of structured, intensive support plus pharmacotherapy may not necessarily be the most effective smoking cessation approach. However, young people can show signs of nicotine dependence and may have tried to quit unsuccessfully in the past⁴. Given this, and the fact that NRT is now licensed for this group on the basis that it is as well tolerated by young people as by adults, is safer than smoking and there is no evidence to suggest that it would be misused⁵, findings from pilot projects support the following recommendations.

Recommendations for working with young people

- a. Discuss with the young person, and use professional judgement, to decide whether or not to offer NRT to young people aged 12–17 who request it or who show clear evidence of nicotine dependence. If NRT is prescribed, offer it as part of a supervised regime.
- b. Neither varenicline nor bupropion is licensed for, and therefore should not be used by, people under the age of 18 years.
- c. Advisers and coordinators should be aware of, and actively consider the importance of, a range of school-based prevention and cessation approaches for this age group, linking in with relevant organisations where appropriate; detailed recommendations are provided in the *Scottish Perspective on NICE Public Health Intervention Guidance 23 – School-based interventions to prevent smoking*, available at www.healthscotland.com/scotlands-health/evidence/NICE.aspx

4.2.3 Pregnant smokers, smokers planning a pregnancy, and partners or other family or household members

See Section 4.3.1 for 'Breastfeeding women, parents of young children, and other family or household members'.

Smoking during pregnancy is the largest single preventable cause of disease and death to the fetus and infants, accounting for a third of peri-natal deaths⁴¹. It is associated with a number of women's health issues as well as fetal and neo-natal problems – complications in pregnancy and labour (e.g. ectopic pregnancy, bleeding due to detachment of the placenta, placenta damage, premature rupture of membranes), pre-term delivery, low birthweight, miscarriages and sudden infant death syndrome (SIDS)^{2,42,47}. Maternal exposure to second-hand smoke (SHS) during pregnancy is associated with persistent adverse effects on lung function throughout childhood⁴⁴. Smoking cessation programmes for pregnant women reduce the proportion of women who continue to smoke, and reduce the risk of low birthweight and pre-term birth⁴⁵ – in fact, women who stop smoking before pregnancy or during the first three–four months of pregnancy reduce the risk of a low birthweight baby to that of a never-smoker⁴⁶. Even in the later stages of pregnancy, it is still of benefit to quit in order to have an impact on this risk^{45,46}, and the increased birthweight and reduced risk of premature birth may make a difference to neonatal health outcomes⁴⁷.

In addition to the type of support available from NHS smoking cessation services (described in Section 3), cognitive behaviour therapy, motivational interviewing and structured self-help support have also been found to be effective for pregnant women to quit smoking³. There is mixed evidence on the effectiveness of NRT in helping women to stop during pregnancy and currently insufficient data to form a judgement about all aspects of its safety³, although the substantial risks to the fetus of the mother's continued smoking would generally be considered to outweigh any potential adverse effects from NRT (which has lower doses of nicotine and none of the other chemicals such as tar and carbon monoxide to which smokers are exposed).

There is a lack of evidence available on whether smoking cessation interventions specifically for those planning a pregnancy or who have recently given birth, as opposed to pregnant women *per se*, are effective or cost-effective³. However, the recommendations that follow should benefit women who smoke and who are planning a pregnancy, are already pregnant, or who have an infant aged under 12 months.

Interventions which are generally effective will not necessarily work with the partners of pregnant women at the time of their partner's pregnancy (e.g. simply providing self-help material or media education campaigns is not effective with this group around the time of pregnancy)³.

Key service implications of the recommendations below include an automatic system of referral to specialist services for self-reported pregnant smokers (or those who have, upon CO validation, a reading that indicates they are likely to be a smoker or those who have quit within the last two weeks) by midwives at first booking. This automatic referral system is recommended to ensure that pregnant women who smoke are provided with the best possible information and accessible support to stop smoking, should they wish to do so.

Pregnant women referred to specialist services automatically by their midwives through this system should receive a follow-up telephone call from the specialist service accepting the referral to discuss the issues of smoking and pregnancy, and the particular needs of the woman concerned. The purpose of this call is to provide an opportunity for the service to explain more about what specialist cessation services offer (which may be specialist/intensive support provided by a specialist pregnancy cessation adviser specifically for pregnant women and their significant others rather than generic specialist/intensive support), clarify any misconceptions about the referral process, and to help the woman better understand the options available to her. Having discussed the benefits of quitting, specialist service information and their flexibility, the woman may decline the offer ('opt out') of the service at this point, or the date of attendance at the service/home visit may be set, as appropriate.

It is important that all the recommendations that follow are carried out with a non-judgemental, client-centred approach maintained at all times. The intention should be to make clear to pregnant women that this is an opportunity for those referred to specialist services to access information and specialist service support, not an obligation to attend services if, after information is provided, they do not wish to do so.

Further information: Validating smoking status during pregnancy

When using CO monitors, the exact cut off point which indicates whether a woman is a smoker or non-smoker is not clear cut, and those who smoke infrequently or inhale very little may be difficult to distinguish from those who are exposed to passive smoking (or other environmental or biological factors)³. The purpose of the initial CO test is to act as an aid to discussion around smoking status to potentially circumvent problems of under- and mis-reporting, as well as identifying other problems which may be contributing to high CO levels.

Regular biochemical validation via CO monitoring may encourage a pregnant woman to quit as well as provide positive feedback once a quit attempt has been made³. Although no measure is 100% accurate, urine or saliva cotinine tests are more accurate than CO monitoring as they can detect exposure over the past few days rather than hours (although the adviser should remain mindful that cotinine levels may be raised among those using nicotine replacement therapy)³. All forms of biochemical validation reduce the likelihood that a smoker may miss out on the opportunity to get help to stop.

The recommendations contained within this section are based on *NICE Public Health Guidance 26 – How to stop smoking in pregnancy and following childbirth*, and contain guidance that enhances existing practice and which has implications for service design. It is recognised that, given the nature of the changes to practice that follow, these recommendations may take time to become embedded in service delivery, and that there are a number of key stakeholder groups involved in making this happen, e.g. service planners and commissioners, smoking cessation managers and staff, midwives and other health professionals. Given the serious consequences of smoking throughout and beyond pregnancy, however, all those who have a responsibility and opportunity to encourage and support pregnant smokers to stop should move towards meeting these recommendations.

Recommendations for working with pregnant smokers

- a. Pregnant women, women smokers who are planning a pregnancy and those with infants under 12 months, should be offered personalised support once they have been fast-tracked to conveniently located and timed specialist cessation service support (with home visits or other flexible options considered if it is difficult for them to attend a service). In order to meet the needs of disadvantaged women in particular, these services should: be delivered in an impartial, client-centred manner; be sensitive to the difficult circumstances many women who smoke find themselves in; take into account other socio-demographic factors (e.g. age, ethnicity, cultural relevance of service provision, and making clear the availability of interpreting services for non-English speakers); involve these women in the planning and development of services; be flexible, co-ordinated, easily accessible and tailored (e.g. through partnership work with outreach schemes and agencies offering support to this target group).
- b. On automatic referral by a midwife at booking:
 - All those who have been referred automatically by a midwife at booking, should be telephoned by a specialist adviser to discuss smoking and pregnancy, and the issues they face, in an impartial and client-centred approach, and invited to the service. If necessary (and resources permitting), they should be phoned twice and followed up with a letter, and the outcome fed back to the maternity booking midwife. An attempt should be made to contact those who cannot be contacted by telephone e.g. during a routine antenatal care visit or when attending for a scan.

- Those who have been automatically referred by a midwife at booking, but who decide (on discussion with the specialist smoking cessation adviser) that they wish to 'opt out', should have this answer accepted non-judgementally, and have the factors which prevent them from using the services (e.g. lack of confidence about their ability to quit, fear of failure or stigmatisation, lack of knowledge about the services on offer, difficulty accessing them or lack of suitable childcare) addressed. If women are reluctant to attend the service, consider providing structured self-help materials, support via telephone or signposting to Smokeline 0800 84 84 84, or consider offering to visit them at home or at another venue if it is difficult for them to attend such a service. Those who decline the offer of support ('opt out') during the initial telephone call, should be sent information about smoking in pregnancy and on how to obtain support at a later date if they wish (and which is easily accessible and available in a variety of formats).
- c. Initial and ongoing support for all women (irrespective of referral route i.e. automatic referral by midwife, from other health and support services for those who want to stop or self-referral):
- During the first face-to-face meeting, discuss how many cigarettes the woman smokes and how frequently; ask if anyone else in the household smokes (including her partner, if she has one).
 - Advise of the dangers of smoking and the hazards of second-hand smoke exposure to their unborn babies and themselves, at the earliest opportunity, and provide information on these risks and of the benefits of stopping for both mother and baby.
 - Address any concerns she (and her partner or family – for further details, see f below) may have about stopping smoking.
 - If partners or other family members are present at the first face-to-face meeting, encourage those who smoke to quit; if they aren't present at the meeting, ask the pregnant woman to suggest that they contact the NHS smoking cessation services and provide her with contact details (e.g. telephone and address card, or Smokeline card from which details of local services will be available).
 - Encouragement, personalised information, advice, and intensive and ongoing support (brief interventions alone are unlikely to be sufficient) on how to stop smoking should be offered throughout the pregnancy and beyond, including the monitoring of smoking status regularly using biochemical validation (CO tests, or preferably the more accurate urine or saliva cotinine measurement) at the quit date and one month follow-up.
 - If, when using CO monitoring, the reading is higher than 10ppm but the woman says that she has stopped smoking, advise her about the possibility of CO poisoning and advise contacting the free Health and Safety Executive gas safety advice line on 0800 300 363; given that it's more likely that she is still smoking, any further questions should be phrased sensitively in order to encourage a frank discussion.
 - Record the method used to quit smoking, including whether or not the woman received help and support, and follow up 12 months after the quit date.

- d. Continued intensive support and smoking status monitoring (including CO monitoring to encourage quitting and provide positive feedback on the quit attempt made) should also be given to women who successfully quit smoking prior to contact with services (in particular, if the pregnant woman stopped smoking in the two weeks prior to her maternity booking appointment), with support continuing to be provided in line with the recommendations above and local service practice protocols, to encourage and help them to stay stopped throughout and beyond the pregnancy.
- e. Pharmacotherapy:
- The risks and benefits of NRT should be discussed with pregnant women who smoke, particularly those who do not wish to accept other help from NHS smoking cessation services, and NRT should only be used if smoking cessation without NRT fails.
 - If a pregnant woman expresses a clear wish to receive NRT, and if smoking cessation without NRT fails or has failed, professional judgement should be used to decide whether to prescribe or provide it. Whilst it cannot guarantee complete safety, the risk to the fetus of the mother's continued smoking generally outweighs any potential adverse effects from NRT. Intermittent forms of NRT are preferable to continuous forms although a patch may be more appropriate if the woman suffers from nausea/vomiting.
 - If prescribed, prescribe only for use once they have stopped smoking (passed their quit date) and prescribe in line with Section 3.3.2 (e.g. two weeks' supply of NRT from their quit date, and subsequent prescriptions only through demonstration on re-assessment that they are still not smoking). Advise pregnant women using nicotine patches to remove them before going to bed to avoid the administration of nicotine overnight (when the fetus would not normally be exposed to smoking-derived nicotine).
 - Neither bupropion nor varenicline is licensed for, and therefore should not be for use by, women who are pregnant, seeking to become pregnant, or breastfeeding.
- f. It is also important to ensure that partners of women who are pregnant or planning a pregnancy, and other family or household members who smoke, are:
- encouraged to quit (either directly, if they are present at the first face-to-face meeting, or this encouragement to quit conveyed via the pregnant woman if they aren't present at this meeting – as in c above)
 - made aware of the risk to the pregnant woman and to the baby (before and after the birth) posed by second-hand smoke
 - recommended (if they aren't able to quit smoking) that they do not smoke around the pregnant woman, mother or baby; this includes not smoking in the house or car
 - given smoking cessation advice and have any concerns about smoking cessation addressed
 - offered timely smoking cessation support, including timely access to an intensive smoking cessation service
 - the support may involve a multi-component intervention comprising several elements and multiple contacts; discuss the options, taking into account the considerations outlined in 3.3.2j in respect of pharmacotherapy use and the support in general.

Supplementary information

Good practice: Pregnant women

A mapping exercise of the extent and nature of smoking cessation support in pregnancy in Scotland⁴⁸ highlights examples of good practice and reinforces recommendations relating to pregnancy throughout this guide. It found that facilitating engagement with the service before support is given is a necessary pre-requisite, and highlighted how CO monitoring at booking visits can help identify smokers and circumvent under-reporting problems as well as encourage clients to consider smoking cessation, and noted the importance of a service responsive to women's needs and which offers flexibility such as telephone support once engaged with a service.

4.3 Recommendations for working with other priority groups

4.3.1 Breastfeeding women, parents of young children, and other family or household members

See Section 4.2.3 for pregnant smokers, smokers planning a pregnancy, and their partners or other family or household members.

Many women relapse to smoking following the birth of the child⁴⁷. There can be a common misperception among partners and other family members that smoking away from (i.e. not in the proximity of, or else blowing smoke in the other direction from) the baby or once a baby has grown into a toddler is relatively safe. Health of children and the home environment are inextricably linked. Exposure to second-hand smoke (SHS or passive smoking) increases the risk of lower respiratory tract infections including bronchitis and pneumonia, and reduces lung function^{42,43,47}. It increases the risk of SIDS (cot death), severity of asthma (frequency of episodes, severity of attacks) and is a risk factor for new cases of asthma^{42,43,44,47}.

Recommendations for working with parents of young children, and other family or household members

- a. It is important to ensure that parents of young children, and other family or household members who smoke, are:
 - made aware of the risk to young children posed by passive smoking (second-hand smoke) and any link with presenting medical conditions, where relevant
 - encouraged to quit, have any concerns about smoking cessation addressed, and given practical and personalised smoking cessation advice
 - offered timely smoking cessation support, including timely access to an intensive smoking cessation service; the support may involve a multi-component intervention comprising several elements and multiple sessions; discuss the options, taking into account the considerations outlined in 3.3.2j in respect of pharmacotherapy use and the support in general
 - recommended, if they aren't able to quit smoking or until such a time that they are, that they do not smoke around the young child; this includes not smoking in the house or car.

b. For breastfeeding mothers, NRT may be recommended to assist a quit attempt. Professional judgement should be used to decide whether to prescribe or provide it (after undertaking a risk-benefit assessment, in which the risks and benefits of NRT are discussed with breastfeeding women who have been unable to stop smoking unaided and who express a clear wish to receive it). However, the risk to the baby of the mother's continued smoking, and of any SHS exposure, is likely to outweigh any potential adverse effects from the comparatively small amount of nicotine in the breast milk from NRT. If prescribed, do so in line with 3.3.2 (e.g. two weeks' supply of NRT from their quit date, and subsequent prescriptions only through demonstration on re-assessment that they are still not smoking).

Intermittent forms of NRT may be more appropriate as their use can be adjusted to maximise the gap in time between dosage and feeding the baby, thus minimising the quantity of nicotine in the milk.

If breastfeeding women do use nicotine patches, advise them to remove them before going to bed to avoid the administration of nicotine overnight when the baby would not normally be exposed to smoking-derived nicotine.

c. Neither bupropion nor varenicline should be used by women who are breastfeeding.

4.3.2 Hospital patients (including patients preparing for hospital admission)

There is a well-established link between smoking and post-operative complications (e.g. increased mortality, pulmonary/respiratory complications, wound complications, delayed recovery). Even short-term cessation prior to surgery or hospitalisation may reduce risk of post-operative complications in comparison with continuing smoking – the longer the smoker is stopped, the greater the health benefits⁴⁹. Those who have an unplanned admission, and therefore who are effectively undergoing enforced cessation, should receive high quality support and advice from practitioners/advisers to help them cope with unplanned cessation, which has the potential to become sustained abstinence. High intensity behavioural interventions which take place during a hospital stay that include at least one month of contact and support after discharge are effective and help promote smoking cessation amongst patients in secondary care⁵⁰, although studies suggest that at least two months post-discharge telephone follow-up is likely to be required in order to be more successful².

Recommendations for working with hospital patients

- a. Patients should be reminded at every suitable opportunity of the health benefits of stopping.
- b. Patients referred for elective surgery, or waiting to be admitted to hospital, should be encouraged to stop smoking before the operation or pre-admission. Those who want to stop smoking should be offered timely access to an intensive/specialist service (for example, an NHS smoking cessation service).

- c. Hospital patients who use tobacco in any form should be offered advice and, if appropriate, NRT (for example, to manage nicotine withdrawal symptoms through an enforced quit) from a suitably trained professional while in hospital, to help them to quit. They should also be offered an appointment with an intensive support service (for example, an NHS smoking cessation service). Intensive smoking cessation services should be provided for patients while in hospital, where appropriate and possible.
- d. Patients waiting to be discharged from hospital, particularly those who have tried to quit smoking in hospital, should be offered, and fast-tracked for, (continued) intensive cessation support, with an appointment booked prior to their discharge.

Supplementary information

Further information: Smoking cessation service for people having elective surgery

This commissioning guide from NICE (available at www.nice.org.uk/PH010 alongside smoking cessation services guidance), although targeted at an audience in England, may provide useful information for staff involved in such service delivery, particularly the sections on quality assurance and service specification.

Good practice: Hospital patients

CEL 14 (2008), the letter from the Scottish Government's Director General – Health, entitled Health Promoting Health Service: Action in Acute Care Settings (www.sehd.scot.nhs.uk/mels/CEL2008_14.pdf) and the mapping exercise/audit relating to smoking cessation support in secondary care (www.healthscotland.com/documents/2664.aspx), provide some recommendations for smoking cessation services for this client group.

Training on tobacco for frontline workers in the secondary care setting has been developed between NHS Health Scotland and PATH, and further details are available in Section 6.

Case studies: Hospital patients

NHS Greater Glasgow and Clyde's service for hospital inpatients includes NRT and smoking cessation service information in the hospital prescribing formulary.

NHS Grampian, as part of the development of pre-operative smoking cessation in partnership with GPs and outpatient consultants, has smoking cessation included on the standard proforma in pre-assessment clinics.

4.3.3 People with heart disease or respiratory disease

Smoking cessation by those with heart or respiratory disease can slow the progression of the disease and reduce the risk of it recurring. For CHD sufferers, within two–four years of having quit, there is a 35% risk reduction in terms of re-infarction or death in comparison with continuing smokers⁵¹. CHD risk is cut by half one year after quitting and becomes similar to that of a never-smoker 10–15 years post-quitting^{46,51}.

Recommendations for working with people with heart disease or respiratory disease

- a. It is important to:
 - ensure that people who have heart or respiratory disease, and those who live with them, are aware of the risks of active and passive smoking (second-hand smoke) to people with such diseases
 - ensure that they are aware of the rapid and longer term benefits to them of not being smokers and not being exposed to second-hand smoke even after being diagnosed with heart disease
 - give them smoking cessation advice
 - offer them fast-tracked (where clinically advisable) and timely access to smoking cessation support.
- b. Evidence suggests that for smokers with **stable heart disease**, the benefits of using NRT to quit smoking outweigh any risks there may be with NRT. If prescription or provision of NRT is being considered with people who have **unstable cardiovascular disorders**, the risks and benefits should be explained. For those in hospital with **severe heart disease**, NRT can be used if recommended and supervised by the doctor treating the patient.
- c. Varenicline or bupropion may be offered to people with unstable (and, by implication, stable) cardiovascular disorders, subject to clinical judgement.

Supplementary information

Further information: Patients with heart or respiratory disease

Allowing for the expanded range of available pharmacotherapies, recommendations are compatible with references to smoking cessation in the following Scottish national clinical guidelines:

- SIGN 97 (Risk Estimation and Prevention of Coronary Heart Disease, 2007 – still current www.sign.ac.uk/pdf/sign97.pdf)
- SIGN 57 (Cardiac Rehabilitation, 2002 – still considered current www.sign.ac.uk/pdf/sign57.pdf)
- SIGN 59 (Community Management of Lower Respiratory Tract Infection in Adults, 2002 – still considered current www.sign.ac.uk/pdf/sign59.pdf)

Good practice: People with heart disease or respiratory disease

The Keep Well anticipatory care pilot programme may provide useful learning here, in relation to providing smoking cessation support for socio-economically disadvantaged communities at increased risk of cardiovascular or respiratory disease.

4.3.4 People with diabetes

Smokers who have diabetes have a considerably increased risk of developing cardiovascular disease and complications of it⁵², and there is some evidence suggesting that smoking is an independent risk factor for diabetes⁵³.

Recommendations for working with people with diabetes

- a. Due to the increased risk of developing cardiovascular disease and associated complications, it is very important that smokers who have diabetes quit smoking. They should be encouraged to attend for behavioural and pharmacotherapy support.
- b. Blood sugar should be monitored more closely when someone with diabetes is trying to stop smoking, since both stopping smoking and the use of NRT affect insulin metabolism.

Supplementary information

Additional information: Patients with diabetes

Allowing for the full range of pharmacotherapies, recommendations in the 'Pharmacotherapy' section of this document are compatible with references to smoking cessation in the following Scottish national clinical guideline:

- SIGN 116 (Management of Diabetes, 2010
- www.sign.ac.uk/pdf/sign116.pdf)

Good practice: Diabetes patients

As both nicotine and the constituents of tobacco have numerous effects on blood sugar metabolism, and quitting smoking (with or without the aid of pharmacotherapy) can alter the body's insulin resistance, with the processes which take place being complex, diabetics should be encouraged to consult with and discuss any attempt to quit with their diabetic team when thinking about quitting, as adjustment of their ongoing diabetes treatment may be necessary.

Diabetics should also consult with their doctor before using bupropion (as per guidance from eMC and MHRA).

Case study: Diabetes patients

NHS Western Isles has a smoking cessation adviser who is a diabetes specialist nurse. This adviser promotes awareness of the link between smoking and diabetes and additionally provides training to support other staff working in diabetes.

4.3.5 People with psychiatric and other mental health problems

Psychiatric patients have very high rates of smoking, particularly those living in either hospital or community-based psychiatric services, where there have traditionally been higher levels of smoking. Smokers with mental health problems show higher levels of dependence⁵⁴ with rates of cardiovascular and respiratory diseases being higher among some mental health groups (such as people with a diagnosis of schizophrenia) than the general population⁵⁵.

Recommendations for working with people with mental health problems

- a. For patients with mental health problems, provide tailored smoking cessation advice; and offer them timely access to an intensive smoking cessation service, with fast tracking where possible.

Supplementary information

Good practice: Patients with psychiatric and other mental health problems

Useful learning may be provided through *Moving Towards Smoke-free in Mental Health Services in Scotland* (www.healthscotland.com/documents/2387.aspx), and from evaluations of ASH Scotland/PATH pilot projects involving people with mental health problems (www.ashscotland.org.uk/ash/3921.html). Consult relevant sources of information outlined in Section 3.3.3 for any pharmacotherapy contraindications.

Patients with schizophrenia, bipolar affective disorder and other psychoses should be offered routine health promotion and prevention advice appropriate for their age, gender and health status. This should be reviewed annually. For smokers, this must include smoking cessation advice and an opportunity to refer patients to smoking cessation services. (General Medical Services GP Contract/Quality and Outcomes Framework, www.isdscotland.org/isd/3365.html).

The considerations described in recommendation 3.3.2j with respect to use of pharmacotherapies by patients with certain conditions or being prescribed other medication, apply to people with mental health problems. Care should be taken when prescribing smoking cessation pharmacotherapy to check for possible interactions with ongoing courses of medication.

Case studies: People with mental health problems

NHS Fife's Kirkcaldy and Levenmouth CHP provides tailored smoking cessation support to adults with mental health problems in partnership with local mental health groups. In the initial stages, a resource pack was produced, staff trained, awareness of smoking cessation issues was raised, and smoking cessation support delivered to those with mental health problems. This work fed into the framework for smoke-free mental health services in NHS Fife, and became the basis for the PATH training programme entitled 'Raising the Issue of Smoking with Mental Health Service Users' (for more information on this see Section 6).

In 2004, the State Hospital, one of four high-security hospitals in the UK which provide a forensic service for patients with mental illness and learning difficulties, established a three-year within-service smoking cessation programme through PATH. Its aim was to provide a tailored service for State Hospital patients to reduce smoking prevalence (78% when the project began in 2004), provide training for staff to deliver this tailored service, and to pilot and establish a service delivery model that worked in this high security setting. The project evaluation was positive, with fears that levels of stress or violence would increase, or that patients would not wish to give up, proving unfounded. Through the work of staff trained to become smoking cessation advisers, by the end of the project's funding period in 2007 the smoking prevalence had dropped from 78% at baseline to 69%. During this time a total of 82 patients attempted to stop smoking with the service, with the project evaluation concluding that the development of smoking cessation services in circumstances where clients have complex mental and physical needs is both possible and desirable. More information on this project can be found at: www.ashscotland.org.uk/ash/4397.html

4.3.6 Prison populations

There is both a high prevalence of smoking within the prison population⁵⁶, and also a high level of mental illness⁵⁷. It is expected that the health care of prisoners will fall within the remit of the NHS Board within which the prison is located.

Recommendations for working with prison populations

For recommendations for those working with prison populations, see recommendations 'e' to 'h' and 'j' in Section 8.1.

Supplementary information

Good practice: Prison population

ASH Scotland pilot projects such as the tobacco and inequalities work in Kilmarnock, have focused on this population. Details are available from www.ashscotland.org.uk/ash/4391.html

Those working with prescription supplies should be aware of prescribing issues in this setting. For example, inmates cannot obtain NRT gum.

4.3.7 Black and minority ethnic groups

Using the Scottish Household Survey's smoking prevalence from 1999 to 2004, the *High Level Summary of Equality Statistics: Key trends for Scotland 2006*⁵⁸ noted that prevalence was lower among minority ethnic groups than among white ethnic groups although percentages were based on small sample sizes.

Smoking prevalence and habits can vary significantly amongst black and minority ethnic groups – they are not homogenous. For example, Pakistani men have smoking rates higher than the male population average but, conversely, Pakistani women have rates much lower than the female average⁶. There are a wide range of different tobacco products in addition to manufactured cigarettes with some types being more common in certain black or minority ethnic groups. For some minority ethnic groups, particularly from South Asia⁵⁹, the use of certain types of non-smoked and chewing tobacco may be more widespread than in the general population. Such products include paan masala, gutkha and mishri.

Smoking cessation interventions tailored for people from minority ethnic groups may be slightly more effective than generic interventions aimed at this group².

Recommendations for working with minority ethnic groups

- a. Ask patients or clients from minority ethnic groups about all forms of tobacco use, not just that which is smoked.
- b. Provide tailored advice and support, particularly to clients from minority ethnic groups. Services should be easily accessible to this target group and they should be encouraged to use them. Provide services in the language chosen by clients, wherever possible. If local services cannot be provided in a client's chosen language, he or she should be signposted to Smokeline through which the LanguageLine facility is available.

Supplementary information

Good practice: Black and minority ethnic groups

There has been targeted support for minority ethnic communities through local tobacco alliances and national pilot smoking cessation projects funded by ASH Scotland and PATH. More information on these projects can be obtained from the relevant organisations.

A useful resource for use with those in minority ethnic groups is a DVD discussing the use of various tobacco products other than manufactured cigarettes, produced by NHS Lothian, the Minority Ethnic Health Inclusion Project (MEHIP) and ASH Scotland, and available directly from MEHIP (0131 537 7565).

4.3.8 People with disabilities

Although the key source materials do not have specific recommendations for this group, the recommendations for those from socio-economically disadvantaged groups could apply equally to some individuals with disabilities.

The Scottish Household Survey (SHS)⁵⁸ estimates that the prevalence of smoking is slightly higher in adults with a disability and/or long-term illness compared to those with no disability and/or long-term illness, and that this is consistent over time. In 2005, the SHS estimated that those with a disability and long-term illness had highest prevalence, and those with neither had lowest prevalence.

Recommendations for working with people with disabilities

- a. Services should provide tailored advice and support.
- b. Services should be easily accessible to this target group and they should be encouraged to use them.

Supplementary information

Case study: People with disabilities

NHS Lothian has developed a DVD of its smoking cessation service leaflet which also includes translation into British Sign Language with subtitles and voiceover. This can be used for those who have a hearing impairment, visual impairment or literacy problems. The self-help booklet is also being translated and all SCS staff are undertaking 'deaf awareness' training.

4.3.9 Older people

There can be a popular misconception that older adults are less interested in quitting (because they perceive it as too late in life to reap any health benefits from doing so, or because they may already be experiencing smoking-related illness), and that they are less likely to quit. However, older adults can enjoy a range of health benefits through cessation⁴⁴, and are actually more likely to quit successfully than younger people^{35,63}.

Recommendations for working with older people

- a. Older smokers should be encouraged to stop as they may already be experiencing smoking-related diseases, but giving up smoking still has benefits by reducing the risk of smoking-related diseases and decreasing the time needed to recover from many illnesses.

Supplementary information

Good practice: Older people

The ASH Scotland/PATH pilot smoking cessation projects with older people may provide useful learning. Information on the projects and summaries are available at www.ashscotland.org.uk/ash/3922.html

4.3.10 People in the workplace

In a review of workplace interventions⁶⁰, individual and group interventions plus pharmacotherapy were shown to increase the likelihood of quitting. These interventions show similar effects whether offered in the workplace or elsewhere, whereas self-help interventions and social support are less effective in the workplace (and elsewhere) than individual and group interventions. Although these interventions show good individual efficacy, because there are relatively few of these interventions, the absolute numbers who quit through this route are low. This suggests that workplace services should be made more widely available.

Recommendations for working with people in workplaces

- a. Smoking cessation services should offer support to employers who want to help their employees to stop smoking and provide support on employers' premises where feasible, focusing in order of priority on small and medium-sized enterprises (SMEs), with a high proportion of employees on low pay, a high proportion of those from disadvantaged backgrounds and heavy smokers. This should be in line with the *NHS Health Scotland Commentary on NICE Public Health Intervention Guidance 5: Workplace health promotion – how to help employees to stop smoking* (NHS Health Scotland, 2007).

Supplementary information

Good practice: People in the workplace

The document *Smoke-free Scotland: Guidance on Smoking Policies for the NHS, Local Authorities and Care Service Providers* (Scottish Executive and others, 2005) – www.scotland.gov.uk/Resource/Doc/47121/0020880.pdf – provides helpful guidance of relevance.

The Scottish Centre for Healthy Working Lives can assist in implementation of smokefree workplace policies including the provision of smoking cessation support. It provides expert, free and confidential advice and support for employers, to help improve health and wellbeing in the workplace, including on tobacco issues such as smokefree workplace policy development. Further information can be obtained at www.healthyworkinglives.com or by calling 0800 019 2211.

Workplace interventions should follow the principles in the *NHS Health Scotland Commentary on NICE Public Health Intervention Guidance 5: Workplace health promotion – how to help employees to stop smoking* (NHS Health Scotland, 2007) – and should be free for employees.

A mapping exercise⁶¹ which described and mapped the nature and extent of smoking cessation support available through the workplace or via smoking cessation services, highlights examples of good practice – www.healthscotland.com/documents/2958.aspx, and reinforces recommendation 4.3.10a.

4.4 Summary: Target groups and priority groups

- Offer tailored advice and support, particularly to those from minority ethnic and disadvantaged (especially socio-economically disadvantaged) groups and other specific population groups e.g. pregnant women, hospital inpatients, those with mental health problems; this may include tailoring to needs, circumstances and preferences, at locations and schedules to suit, within reason and/or where feasible.
- Offer easily accessible services to those from minority ethnic and disadvantaged groups, and encourage these clients to use them.
- With groups for whom NRT has recently been licensed (pregnant women, breastfeeding women, young people, those with unstable cardiovascular disease):
 - especially encourage them to attend services to maximise the benefits of NRT (if provided/prescribed)
 - undertake a risk-benefit assessment prior to prescribing/providing NRT (but bear in mind that it will almost certainly be safer to take NRT than to continue smoking).
- Fast-track pregnant women, those being discharged from hospital and those who have tried to quit in hospital, into services.
- Provide timely access to services for those waiting to be admitted to hospital, for hospital patients, for cardiac/respiratory patients, and for breastfeeding women.
- Remind patients/clients of the dangers of smoking (including the benefits of stopping, and linking in with medical conditions) and the hazards of second-hand smoke, especially for pregnant women, breastfeeding women or young families, hospital patients, and heart/respiratory disease patients.

5 Monitoring and use of data

5.1 A national minimum dataset for monitoring NHS smoking cessation services in Scotland was introduced in April 2005, with the first full calendar year of national recording being 2006. The dataset* was developed by PATH in consultation with services, NHS Information Services Division (ISD) Scotland and others. The development of the dataset and accompanying electronic database has increased the validity and consistency of smoking cessation data gathered for both local and national purposes.

Information Services Division (ISD) Scotland established and manages the above-mentioned electronic, web-based system for gathering data – the National Smoking Cessation Database for monitoring NHS smoking cessation services. This system allows NHS smoking cessation services to capture the core minimum dataset information, a wide range of locally collected data items, and provides a range of statistical reporting and other features.

Access to the database is arranged by registering through the local smoking cessation services and/or the NHS Board smoking cessation coordinator.

Recommendations: Monitoring and use of data

- a. Audit performance data routinely including quit attempts and dates, a range of socio-economic data, and outcome data at one, three and 12 months using the national smoking cessation database.

5.2 The output from ISD Scotland's National Smoking Cessation Database** is the only data recognised by, and used by, the Scottish Government for performance management purposes and in particular for the HEAT 6 target.

Its focus is on clients' quit attempts and dates, key demographic characteristics of these clients, and outcomes at one, three and 12 months post quit-date, rather than on the services themselves. It is a tool designed to provide consistent information on clients who access, and set a quit date with, an NHS specialist smoking cessation service as per the definition in Section 2.3.

*Details of the dataset, guidance, and other downloads are available from:
www.ashscotland.org.uk/ash/4240.html

**NHS Greater Glasgow and Clyde use their own local database but provide data extracts for incorporation with the national database extracts for the national analyses. There are also plans for the future electronic transfer of data directly to the national database.

For these reasons, it is recognised that this system measures only one aspect of smoking cessation service work – it does not measure all the smoking cessation activity undertaken by a service (such as brief intervention support, one-off sessions, support in which the client does not set a quit date, relapse support, support for clients who have already quit). It also does not gather data on those who quit smoking without support from NHS smoking cessation services.

5.3 CO (carbon monoxide) verification is not specified as a requirement within the smoking cessation services HEAT target; however, the PATH guidelines currently include CO verification as the recommended standard at the one-month post quit-date stage.

5.4 National performance data on NHS smoking cessation services (uptake and quit outcomes) are produced annually by ISD Scotland from the National Smoking Cessation Database. To date, there are four annual reports, available from:

2009 quit date data www.scotpho.org.uk/smokingcessationstats2009/

2008 quit date data www.scotpho.org.uk/smokingcessationstats2008/

2007 quit date data www.scotpho.org.uk/smokingcessationstats2007/

2006 quit date data www.scotpho.org.uk/smokingcessationstats2006/

From December 2009, short supplementary reports are being produced to support the HEAT 6 target monitoring.

5.5 The national database provides an array of reporting and analysis features that NHS Boards may proactively make use of to produce regular (e.g. monthly or quarterly) local interim reports. Local reporting can inform practice by identifying gaps in service coverage, monitoring progress towards targets, and measuring the efficacy of services in reaching particular groups. ISD offers database training on the use of the report and extract facilities to any database users upon request.

5.6 Supplementary information

Case studies: Monitoring and use of data

NHS Grampian has been working on a number of measures to increase the efficiency of its service. These include:

- A thorough data entry policy, reflecting the contribution that all staff have to make to data gathering and entry; as well as the minimum dataset, it includes completion of data from referral and registration through to the 12-month follow-up.
- A 'clinical and waiting list administrator' who uses patient administration system (PAS) clinic booking software to manage the client journey through the service, allocates sessions and sends appointment letters and information – this frees up the smoking cessation advisers from setting up sessions and booking in clients and enables them to focus on service delivery contact with clients.
- A partnership with The Essentia Group, in which The Essentia Group conduct telephone follow-up calls; the successful contact rate since its inception has been 70%.

NHS Western Isles has enabled training for all staff on the national smoking cessation database, and this has significantly improved compliance with, and standard of, data entry.

NHS Borders has a special monitoring procedure specifically for pharmacists taking part in the national pharmacy scheme. All staff providing smoking cessation in the Borders are required to use the local triplicate pad which contains the national minimum dataset questions. Pharmacy staff then send a copy of the form into the service centrally after they have completed the one-month follow-up information. The information is entered centrally and three month and 12 month follow-ups are also carried out centrally to ease the workload of pharmacy staff and to increase compliance with data collection requirements.

NHS Fife's Dumfermline and West Fife CHP has also undertaken a variety of measures to increase data entry standards which include:

- The development and use of a paper-based version of the national smoking cessation database that matches the flow of the database and assists administrators with data input.
- Smoking cessation specialist advisers complete paper copy forms at the first visit and pass these on to administrators to enter onto the national smoking cessation database within one week of the client's first visit; the adviser is then able to update the database at or following subsequent appointments.
- Other practitioners (e.g. health visitors, pharmacists) complete forms up to and including the one-month follow-up; these are sent to, and input by, the administrators.
- Administrators undertake regular searches to check for missing data and follow up with advisers and practitioners as necessary.

- Administrators write to clients who have missed their appointment around the one-month follow-up in order to ascertain smoking status at this timeframe; this enables the input of data for such clients, many of whom have quit smoking, and who would otherwise have been recorded as 'lost to follow-up'.
- Follow-up letters are sent out within two weeks of the 'due date' for the three-month and 12-month follow-ups.

NHS Fife's Kirkcaldy and Levenmouth CHP:

- Smoking cessation specialist advisers attempt a telephone follow-up for those who have missed their appointment around the one-month post quit-date follow-up in order to ascertain smoking status; if unsuccessful, administration staff will attempt both a daytime and an evening telephone call in the first instance, an email and then a letter enclosing a stamped addressed envelope.

5.7 Summary

- When coordinating monitoring:
 - Ensure that audit performance data, including quit attempts and dates, a range of socio-economic data and outcome data, is routinely audited using the national smoking cessation database in accordance with the PATH guidance.
- A smoking cessation specialist/adviser or other provider of intensive support should ensure:
 - that they familiarise themselves with the national minimum dataset for cessation services (MDS) and accompanying guidelines for use, see www.ashscotland.org.uk/ash/4240.html
 - that performance data, including quit attempts and dates, a range of socio-economic data and outcome data, is routinely audited using the national smoking cessation database in accordance with the PATH guidance.

6 Training

Recommendations for training and training standards

- a. Training should be available for, and taken up by, all staff (whether from the NHS, local authority, or community and voluntary sector) who could potentially provide smoking cessation support, whether at brief intervention or at more intensive level, and/or who could advise on or prescribe pharmacotherapies. This is in line with CEL (14) 2008.
- b. Training undertaken should be commensurate with the level/type of support offered or intended to be offered.
- c. Tobacco education and smoking cessation should form part of the core curriculum of basic training for all healthcare professionals. Students in the health and caring professions at schools of medicine, nursing and midwifery, pharmacy and dentistry should be trained and updated via CPD in tobacco education and in how to help people stop smoking.
- d. Locally developed and locally available training should comply with the *Scottish National Training Standards: stop-smoking support*.
- e. Staff providing specialist/intensive/behavioural support should have received appropriate training and be expected to undertake relevant and appropriate ongoing CPD to update their knowledge and skills.
- f. Where telephone support is offered, staff providing such support should be trained to at least 'individual behavioural support' level.
- g. Additional, specialised training should be available for those working with specific groups, e.g. people with mental health problems, those who are hospitalised and pregnant women who smoke. This is in line with CEL (14) 2008.
- h. All training in relation to smoking and pregnancy should address the barriers that some professionals may feel when they try to raise the issue of smoking during pregnancy (e.g. damaging the relationship between client and professional) and the important role that partners and 'significant others' can play in helping pregnant smokers (or women who have recently given birth) to quit.
- i. All training for specialist advisers and midwives who work with pregnant women should cover: how to ask questions in such a way that encourages the client to be open about their smoking and that of anyone else in their household; the use of CO monitors both practically and as a motivational tool; and the recommendation to quit completely rather than cut down.
- j. All midwives who deliver specialist/intensive smoking cessation support should be: trained to the same standard as specialist smoking cessation advisers; provided with additional, specialised training; and offered ongoing support and updates.

6.1 *Scottish National Training Standards: stop-smoking support* (see www.ashscotland.org.uk/ash/6758.html) are quality standards for smoking cessation training in Scotland, which cover both brief intervention and intensive/behavioural support. These were developed in order to ensure that training provision is evidence-informed, consistent and to the same standards across Scotland. They update and replace the original *2003 Standards for Smoking Cessation Training in Scotland*.

6.2 Partnership Action on Tobacco and Health (PATH) provides two nationally available smoking cessation modules at specialist level which are accredited by Glasgow Caledonian University – these modules cover specialist 1:1 interventions, group work and wider tobacco control issues. Details are available from PATH at www.ashscotland.org.uk/ash/4067.html

6.3 Details of locally available training are available from NHS Board smoking cessation coordinators or from local NHS smoking cessation services.

6.4 NHS Health Scotland – see www.healthscotland.com/learning/index.aspx – commissioned ASH Scotland to develop a generic brief intervention training course aimed at health professionals, entitled ‘Raising the Issue of Smoking’, on how to deliver opportunistic, brief advice, primarily in healthcare settings. In addition to the generic course, PATH has also developed two courses for tailored interventions with specific groups: ‘Raising the Issue of Smoking During Pregnancy’ and ‘Raising the Issue of Smoking with Mental Health Service Users’. The former two use a blended approach which includes an eLearning module (developing knowledge) and a face-to-face session (developing attitudes and skills), in line with CEL 14 (2008) (letter from the Scottish Government’s Director General – Health). The latter course is a one-day long, face-to-face course.

6.5 Supplementary information

Good practice: Telephone support staff

Telephone quitline staff who offer support should, in addition to the training recommended above, undertake specific telephone skills training as a precursor to support provision.

Case studies: Training and training standards

NHS Greater Glasgow and Clyde promote training via a number of means including:

- flyers in a variety of locations
- staff briefings at ward level within hospitals
- good relationships built with the ward staff, due to being based on site, enabling the advisers to discuss informally the benefits of attending the training – in turn the staff promote the training to other staff within the ward
- working closely with departments such as cardiac rehab and their allied health professionals, mental health and maternity, who raise the issue of smoking

- running courses on site
- linking with teaching hospitals' sub deans who run programmes for medical students on placement, and with postgraduate centres' teaching programmes for Foundation Year 1 and Foundation Year 2 doctors, at least to raise awareness within the acute setting of smoking cessation services available within the NHS Board area if they are not attending full brief intervention training courses
- linking with hospitals' postgraduate centres and their lunchtime lecture programmes to present for 30–60 minutes to address the major issues, whet their appetites, and promote the services and further training, which often results in a team manager requesting more training for a whole team
- board-wide intranet and email networks.

NHS Borders provide annual updates in training which cover new information on pharmacotherapy, an update on the provision of support to clients, updates on new developments within the smoking cessation service, an opportunity to discuss any difficulties that have been encountered in providing smoking cessation over the year with other practitioners /advisers and up-to-date smoking cessation practitioner/adviser lists to ensure cross-referral. These updates are mandatory for all staff who provide smoking cessation as part of their work.

NHS Lanarkshire piloted the 'Raising the Issue of Smoking During Pregnancy' training in March 2009. Following on from the positive feedback received from the pilot, NHS Lanarkshire are rolling out this training and running the programme every two months from autumn 2009 to train every midwife.

6.6 Summary

- When commissioning training or coordinating training or services, ensure that:
 - it is available for, and taken up by, all staff who could potentially provide support (brief or intensive) and pharmacotherapies
 - the training provided is commensurate with the level/type of support provided
 - students in the health and caring professions are trained, and links are made with health professional schools to ensure that smoking cessation is part of the core curriculum
 - locally developed training complies with the Scottish National Training Standards
 - additional, specialised training is available/accessible for those working with specific groups.
- A provider of intensive/specialist smoking cessation support, including providers of telephone support, should:
 - attend smoking cessation training, which complies with the national standards, and which is commensurate with the type of support provided
 - undertake relevant CPD
 - take up additional, specialised training if working with specific groups.

Part 2: Commissioning and planning specialist smoking cessation services

This section focuses on the planning, provision, structure, set-up, models and operationalisation of specialist services. As outlined in Section 1.1.2, this section builds upon the strong quality assured evidence and recommendations of **Part 1: Providing and delivering**, by providing additional 'good practice' examples for cessation services which may not necessarily be backed up by as strong or quality assured evidence as the recommendations given in Part 1 (where the recommendations are in line with NICE guidance).

Recommendations and examples in this section of the resource, with the exception of those in Section 7.2.1 and Section 8.1 which feature NICE guidance, are primarily from the commissioning section within the Department of Health's *NHS Stop Smoking Services' Service and Monitoring Guidance 2010/11 (DH Guidance)*, which provides guidance and principles for the delivery and commissioning of services to improve the quality and consistency of support provided. These recommendations and 'good practice' examples are derived from service evaluations, observation and previous guidance, and are supplemented with case study examples from around Scotland.

7 Background, local structures, governance and funding

7.1 Tobacco and smoking cessation policy and developments in Scotland

7.1.1 Tobacco control developments which have taken place have included:

- investment in, and development of, smoking cessation services (SCSs) in Scotland
- the upgrade of an existing national tobacco control strategy group to a Ministerial Working Group on Tobacco
- the publication of the Tobacco Control Action Plan, *A Breath of Fresh Air for Scotland* (as outlined in Section 1.2.3)
- the development of PATH (as outlined in Section 1.2.3)
- a national programme of eight pilot smoking cessation interventions aimed at young people (evaluation available at www.healthscotland.com/documents/1381.aspx)

- the publication of the *Smoking Prevention Action Plan* (2008) which focuses specifically on protecting young people from tobacco and preventing them from smoking (available at www.scotland.gov.uk/Publications/2008/05/19144342/0)
- £1.5 million investment in smoking prevention
- multi-media communications campaigns and a range of health education resources have been developed and regularly revised and updated
- legislative action around smoke-free public places and age of sales for tobacco which came into force in March 2006 and October 2007 respectively; a bill that passed through the Scottish Parliament in January 2010 reforms further aspects of tobacco sales law (including prohibiting retail display of tobacco products and banning cigarette vending machines).

7.1.2 Smoking cessation developments

The Scottish Government has continued a commitment to funding smoking cessation services in their allocation letters to NHS Boards. Funding for specialist services has increased considerably since they were set up across Scotland following the publication of the UK-wide Tobacco White Paper *Smoking Kills* (December 1998) – the first comprehensive strategy to address tobacco issues.

Since *Smoking Kills*, a wide variety of advancements have collectively enabled the development of smoking cessation services throughout Scotland, including:

- the publication of Smoking Cessation Guidelines for Scotland (2000, 2004 update and its 2007 supplement)
- availability of pharmacotherapies such as NRT, bupropion and varenicline on prescription
- investment in pilot projects researching cessation with specific groups
- a programme of investment in smoking cessation services.

Funding

A total of £14 million is currently invested annually in smoking cessation services in Scotland, £2 million of which is in NHS Boards' unified budgets. This funding includes £3 million for smoking cessation delivered through a national pharmacy scheme established in 2008 and which is outlined in Section 8 of this publication.

Monitoring and outcomes

The performance of Scottish smoking cessation services is monitored nationally through NHS Information Service Division's electronic national smoking cessation database. National data is reported on annually with 2006 being the first year of recording. Figure 8 on page 75 gives an indication of the volume of quit attempts made, and one-month outcome success over the last four years of recording.

7.2 Commissioning high quality smoking cessation services

7.2.1 Core elements of smoking cessation services

Specialist cessation services across Scotland all share a common definition, national targets, and are subject to the same policy drivers and associated funding allocations from the Scottish Government to reduce smoking prevalence among socio-economically deprived communities, pregnant women and young people. While there is commonality between services based on these shared features, and based on implementation of the evidence on good practice in smoking cessation, the specific approach taken by each service varies throughout the country. Services are set up to deliver the same goals, but as they operate in different contexts, there is no easily identifiable 'one size fits all' approach.

Service features such as the type of interventions offered (the balance of 1:1 versus group support), the type of venue in which they are offered (extent of support provided within or outwith NHS premises), and degree of integration with various parts of the NHS (whether closely integrated with primary and/or secondary care or not), can vary depending upon factors such as geography, population density, resources available, knowledge and experience of the staff, service developments, and outcomes of monitoring and evaluation.

Although there is some natural divergence in models of service provision due to these factors, the core elements of smoking cessation services rest around a series of general principles and recommendations in terms of organisation and implementation. Although these general recommendations should be followed, services may show variety and innovation in how these are met, depending on their own local contexts, in order to best reach and help their local population of smokers to quit smoking.

Key principles of specialist smoking cessation services in Scotland

- Funding of services should be permanent and a core part of NHS Scotland provision.
- NHS Boards should determine funding priorities at local level and should provide a Board-wide smoking cessation service (SCS) which is open to all smokers motivated to quit.
- NHS Boards should have a Board-wide SCS strategy and/or a tobacco control strategy in which effective specialist SCSs are included.
- Depending on the geography, size and density of the population, the service(s) may be organised within that NHS Board's overall Board-wide SCS strategy at health board level, CHP level or with one CHP integrating and managing the smoking cessation services on behalf of others, but with overall coordination at NHS Board level (with an advisory/coordinating committee to enable this) in order to produce cost-effective and significant health improvement.

- The NHS Board smoking cessation coordinators generally have overall responsibility for the management, running, coordination and evaluation of all aspects of the service, as well as updating local health professionals about services available in the area; other staff within services should include smoking cessation specialists/ advisers (who provide behavioural and pharmacotherapy support to smokers) and administrative support.
- The support should be carried out by specially trained staff.

Recommendations for smoking cessation services – support provision

- Ensure NHS Boards' smoking cessation services maintain a good service, of sufficient scale and organisation to meet the needs of the population and geography, by maintaining adequate staffing levels, including a full-time NHS Board smoking cessation coordinator.
- NHS Boards' smoking cessation services should ensure both quality and timely referral to meet demand and needs of the population (in particular, in terms of potential clients for whom urgency and fast-tracking is or may be paramount) in order to optimise successful quitting as early as possible.
- Smoking cessation services should target hard-to-reach and deprived communities including minority ethnic groups, and pay particular attention to their needs. See Section 8 for further details of support with these particular population groups.
- Smoking cessation support should be available in NHS (e.g. primary and secondary care) and non-NHS (e.g. community halls, libraries) settings and be available to all smokers who are motivated to quit.
- Establish links between various services e.g. NHS Boards' smoking cessation services should ensure that they have good links with their local hospital care services (and can provide timely cessation support for patients in, or awaiting admission or discharge from, hospital), and should ensure good links with and between maternity services (to obtain referrals and to ensure that health professionals make use of the multiple opportunities to offer advice), with fast-track referral systems in place, particularly for those patients who are pregnant or who have tried to quit smoking in hospital. In addition, intensive smoking cessation services should be provided for patients while in hospital, and conveniently located and timed services for pregnant women should be available. See Section 8 for further details of support with these particular population groups.
- Smoking cessation services should offer a combination of treatments that have proven to be effective, i.e. structured face-to-face behavioural support (both groups and 1:1 support where feasible), and pharmacotherapies (NRT, bupropion and varenicline) – see Section 3 for further information on these – that have evidence of effectiveness.

- g. Behavioural support should be provided from a trained adviser, i.e. with training having been undertaken that is commensurate with the level of support provided and that complies with national training standards (see Section 6.1 for further details). This support should be provided by specially trained advisers either employed for, or with dedicated time set aside for, that purpose and not by health professionals as part of their routine care.
- h. Where telephone support is offered as part of the service, it should provide a rapid, positive and authoritative response. Callers whose first language is not English should have access to information and support in their chosen language such as that provided by LanguageLine for Smokeline callers.
- i. Other types of public health interventions, such as No Smoking Day, Smokeline, www.canstopsmoking.com, communications campaigns and publicity, and health education resources, should be used where appropriate to support the NHS smoking cessation effort and direct smokers towards NHS smoking cessation services. Coordinate locally (i.e. at NHS Board level), in partnership with other organisations (e.g. local government), communication strategies around promoting services and to support those at national level.

Recommendations for wider issues pertaining to smoking cessation services – service planning

- a. For service planning, maintain an awareness of the prevalence of smoking and characteristics of the local population of people who smoke or use other forms of tobacco – a range of information on these is available from the sources cited in Section 1.2.5.
- b. Audit performance data routinely including quit attempts and dates, a range of socio-economic data, and outcome data at one, three and 12 months using the national smoking cessation database.
- c. Training should be available for, and taken up by, all staff (whether from the NHS, local authority, or community and voluntary sector) who could potentially provide smoking cessation support, whether at brief intervention or at more intensive level, and/or who could advise on or prescribe pharmacotherapies. All training provided and undertaken should comply with national training standards in smoking cessation (*Scottish National Training Standards: stop smoking support*) and be commensurate with the level of support offered.
- d. Training at brief intervention level should ensure that it covers how to ask about all forms of tobacco use, advise on the dangers of SHS, and how to make referrals. Training for staff involved with provision of telephone support should be to at least 'individual behavioural support' level (and to 'brief intervention' level for administrative staff within telephone smoking cessation services who do not provide support). Training and CPD/updates for staff involved in the provision of specialist smoking cessation support should be commensurate with that level of support.

- e. Link with health professional schools of medicine, nursing and midwifery, pharmacy and dentistry, to ensure that tobacco education and smoking cessation form part of the core curriculum of basic training (and updates via CPD).
- f. Locally developed and locally provided training should comply with the national training standards.
- g. Additional, specialised training should be available for those working with specific groups, e.g. people with mental health problems, those who are hospitalised and pregnant women who smoke.
- h. Training in relation to smoking and pregnancy should address the barriers some professionals may feel when they try to raise the issue of smoking during pregnancy (e.g. damaging the relationship between client and professional) and the important role that partners and 'significant others' can play in helping pregnant smokers (or women who have recently given birth) to quit.
- i. All midwives who are not specialist smoking cessation advisers should be trained: to assess and record people's smoking status and readiness to quit; to know how to ask questions in such a way that encourages clients to be open about their smoking and that of anyone else in their household; to know about the health risks of smoking, the benefits of quitting and why it can be difficult to stop; to recommend quitting rather than cutting down; how to use CO monitors both practically and as a motivational tool; and in what services offer, and in how to refer to local services (Note: midwives who are not specialist smoking cessation advisers are not recommended to provide smoking cessation support with pregnant women, but instead to use these skills to initiate a referral to specialist smoking cessation services). All healthcare and other professionals who work with women who smoke and are pregnant, planning a pregnancy or have an infant under 12 months (e.g. GPs, medical and dental staff, sonographers, practice nurses, health visitors, family nurses, those who work in youth and teenage pregnancy services, children's centres, social services, and voluntary and community organisations), should be trained to the same standard as midwives who are not specialist smoking cessation advisers.
- j. All training for specialist advisers who work with pregnant women should cover: how to ask questions in such a way that encourages the client to be open about their smoking; the use of CO monitors; and the recommendation to quit completely rather than cut down.
- k. All midwives who deliver specialist/intensive smoking cessation support should be: trained to the same standard as specialist smoking cessation advisers; provided with additional, specialised training; and offered ongoing support and updates.

7.2.2 Supplementary information: Good practice elements – commissioning, coordinating and managing services issues

Evidence-based support to stop smoking is highly cost-effective and clinically effective and should always be offered to people who express an interest in stopping (more detailed discussions on efficacy are available in Section 3). In addition to intervention efficacy, there are other features of importance in the commissioning and operationalisation of services.

In terms of broader context, smoking cessation services should always be considered as one part of a larger tobacco control strategy or programme, and in this way should form part of comprehensive action to reduce tobacco-related harm.

The Department of Health guidance refers to a number of other key issues which NHS Board smoking cessation services should consider in service development and operationalisation. These will be focused on in further detail later in this section.

The box below outlines general issues to consider within the commissioning role for specialist smoking cessation services. Sections that follow deal with specific topics including service provision, referral systems, and service marketing.

Good practice: Commissioning aspects (based on Department of Health Guidance¹⁶)

- Obtain local prevalence and current activity data on smoking populations, including those in high-risk groups if feasible.
- Ensure that local intelligence, community engagement and customer evaluation inform the development of smoking cessation services.
- Service development can be informed by the national smoking cessation database monitoring system – the national smoking cessation database has an array of reporting and analysis features which should be built into service planning to help provide information around targets and operational activity, and which could be used proactively to design services more accurately.
- Ascertain if services offer optimum balance of high-efficacy treatment, reach and accessibility.
- Ensure that services offer a wide range of interventions (to enable choice and taking into account individual characteristics and other factors – outlined above in *Key Principles of Specialist Smoking Cessation Services*) that are consistent with the evidence-base (see Section 3 for recommendations and evidence) to optimise success. Due to the individual characteristics of the client (personal preferences or circumstances; suitability of the various pharmacotherapies) and other factors (different interventions may work with different smokers, or the same intervention may fail to prevent a smoker relapsing on one occasion but succeed on another), it is vital that services offer the widest possible range of evidence-informed interventions.

- In order to achieve the maximum chances of quit success (through intensive behavioural support combined with pharmacotherapy), specialist SCSs should have pharmacotherapy available and accessible through them, in line with their local dispensing practices.
- NHS Boards should design and be able to deliver the right type of service for their area, taking into account priority individuals and groups, and smoking cessation in certain sectors, e.g. secondary care, primary care, workplace, mental health, etc.
- The need for services to be evidence-based should not preclude new research and pilot projects around improving both uptake and effectiveness of services, provided that a robust evaluation component including adherence to national monitoring standards is incorporated within this. The smoking cessation field, although well-researched, is still relatively new, and ongoing work is required in order to evaluate initiatives and programmes which contribute to the evidence (e.g. the Tayside incentive schemes, the Keep Well and Equally Well initiatives).
- Ensure set-up of clinical governance and quality assurance systems to monitor service and service provider quality, and facilitate independent audits.
- Ensure that the smoking cessation message gets across through integrating national and local marketing (to reinforce motivation to quit and to access the smoking cessation services).
- Ensure that services are fully integrated through working with other local providers of smoking cessation support and/or part of other commissioned services and/or with other service providers (e.g. pharmacies, dentistry colleagues, primary care).
- Ensure formal referral systems from primary and secondary care, as well as from other population settings e.g. mental health.
- Budget considerations (see page 74 for further details).
- Administration considerations (see page 75 for further details).
- Telephone quitline staff should, in addition to 'individual behavioural support' training for those offering support (or 'brief intervention' training for those providing administrative support to the telephone quitline service), undertake specific telephone skills training.
- Healthcare students should be trained in generic and lifestyle topic-based brief interventions.
- Ensure that smoking cessation staff have access to CPD.

Case studies from around Scotland: Commissioning aspects (service models)

NHS Lanarkshire, with the introduction of Community Health Partnership structures in 2006, brought together former local health care cooperative (LHCC)-based smoking cessation services under one central service in contrast to the previous structure in which services varied across each LHCC and there was no single contact for the service. The service was subsequently rebranded with the slogan 'It Works!', and a single telephone number and text number for the service were launched at Motherwell Football Club in May 2008. This allows a single access point for service users and also allows users to access the service anywhere in Lanarkshire, i.e. near their work or home. Clinics are run in health centres, community venues and local workplaces. The team work closely with NHS staff and wider CHP partners within each area to promote the service and encourage referrals. The single service approach has also brought the team together into geographical cluster offices which enable the team to work together to target areas of low uptake and to share administrative support. This has allowed better cover for clinics and timely data entry and follow-up monitoring in line with service standards.

NHS Fife's Kirkcaldy and Levenmouth CHP programme for those with mental health problems became embedded into the mainstream smoking cessation service, and tailored support is available to those with mental health problems.

Service provision

Commissioners and providers should work together to achieve outcomes using evidence-informed interventions. They should focus on increasing reach and access to services¹⁶. Services will need to maximise and sustain potential quits by ensuring that the most effective and well-evidenced approaches are used. Concerted service provision and tailoring of actions for target and priority groups is required in order to contribute to reducing social inequalities in tobacco use and health inequalities in general or at least minimise the risk of widening health inequalities.

Taking into account that services provided will be evidence-informed, reach and efficacy of the services provided can be balanced by offering a combination of interventions that are appropriate to the needs and preferences of the local population, being mindful of the diversity of the local smoking population and reaching those who suffer health and social inequalities. In other words, the need for widely accessible services (e.g. pharmacy services, or individual and telephone support) must be balanced against the need for high efficacy rates (standard, 'closed' group interventions). A menu of options should be provided to potential clients along with efficacy rates and accompanying information so that they may make an informed choice.

As highlighted in Section 7.2.1, services are expected to reach and help their local population of smokers to quit smoking as best they can, which may involve showing variety and innovation in how these general recommendations are met, depending on

local context, in order to make services accessible and appropriate to the needs of the local population. The DH guidance also highlights that services and types of intervention need to be configured according to local needs. Understanding those needs, and the impact of each type of service provision on prevalence, is important to align services with needs. One way this can be achieved is through data profiling – such data, including community health and wellbeing profiles at CHP level, are available from www.scotpho.org.uk

Quality principles for smoking cessation interventions: Service provision (derived from Department of Health guidance¹⁶)

- Services and interventions provided should be evidence-informed, in line with NICE and the well-established evidence-base. (*Helping smokers to stop* and *Part 1: Providing and delivering* focus on effective and cost-effective smoking cessation support and components of these).
- Only methods recommended by NICE, and therefore within this guide, should be funded by NHS Boards.
- Although services will vary in the types of intervention they choose to provide and in their approaches to delivery, the quality of services should remain consistent and be maintained by a set of clear principles (these are outlined in Section 7.2.1).
- To optimise success, all recommended treatments and pharmacotherapies should be offered as first-line interventions.
- The first input at specialist smoking cessation services should be maximal, offering both behavioural support and pharmacotherapy, in order to maximise outcomes.
- Service provision should be marketed effectively to as many smokers as possible.
- Service provision should include interventions that are appropriate to the local population's needs, preferences and diversity, while reaching those with health and social inequalities such as the target and other priority groups outlined in Section 4.
- New, non-evidence-based delivery models (such as rolling groups or drop-ins) may be piloted on a small scale and should be carefully evaluated before being adopted as a significant part of the service.
- Staff delivering rolling groups or drop-ins should be trained to national standards, and such interventions should be delivered or supervised by experienced specialists with sufficient expertise to support quitters at different stages of the quitting process simultaneously.
- Interventions should be efficiently managed with sufficient administrative support for general organisation, client contact processes and data handling; there should be sufficient administrative support to ensure that clients are contacted within a week of being made known to the NHS smoking cessation services (further details on administration are provided on page 75).

Good practice: Service provision/improvement issues

Configuration of services/service improvement

Issues to consider when designing an equitable service include:

- being able to respond to new developments (such as in pharmacotherapies)
- basing service development on feedback or reports from the national smoking cessation database (e.g. using database analysis features to determine direction/changes to service delivery).

Prescribing/pharmacotherapies

Issues to consider include:

- ensuring appropriate pharmacotherapies are listed on local formularies, in line with the evidence
- local protocols for prescribing, dual therapy protocols, local guidance
- local monitoring of prescribing.

Quality assurance

Commissioners and service managers should develop and implement high-quality standards, indicators, and monitoring procedures. Quality assurance in smoking cessation services is of considerable importance. As smoking cessation is a (potentially) life-saving treatment, it is important that interventions commissioned and delivered are evidence-informed as current investment in quality should reduce future ill-health costs.

Marketing of services

This includes marketing of services to other staff, raising the profile of the service in order to increase accessibility to target and priority groups, and marketing the service to clients.

Promotion of services should be based on local intelligence, and integration with national campaigns should enhance their effectiveness. Nationally branded materials provided for local promotion can help smokers identify with local support services and promote self-referrals to ensure that the impact of national campaigns is capitalised upon¹⁶.

Good practice: Local promotion of services

Methods used to promote services locally vary ranging from clients' word-of-mouth, to health professionals promoting services during consultations, to posters in primary care such as health centres and GP surgeries, to proactive leaflet distribution throughout a health board area in community venues, NHS or workplaces, to promotion of services around the annual No Smoking Day or World No Tobacco Day, to concerted advertising or media campaigns promoting services. Additionally, roadshows have been held around Scotland to attract new clients at which information is provided, brief advice given and appointments arranged.

Case study: Local promotion of services

NHS Dumfries and Galloway, given its rural demographic characteristics, spends a substantial proportion of its budget on advertising the service, in order to encourage greater uptake. It links national and local campaigns together, has a distinct identity and branding, and brings together local planning/marketing groups – involving key partners such as TV, radio, NHS and local authorities' communications departments – to ensure that campaigns are integrated with a plan over a specified length of time (e.g. one year) and that promotions of services are timed for traditionally quieter times of year in terms of service demand in order to spread demand for services throughout the year.

Referral systems

In order to increase accessibility of services, referral opportunities need to be maximised. Referral protocols and pathways are needed within the NHS and the wider professional community as well as self-referral protocols and procedures.

The level of provision of brief advice and brief interventions in any health board area is crucial in increasing the number of referrals to specialist services. As outlined in Section 8, target groups and other priority groups, plus key NHS and other staff, are prime sources for and of referrals respectively. Increased referral rates, as well as brief intervention provision triggering a quit attempt, will increase quit attempts and actual quits, contributing significantly towards meeting challenging HEAT targets as well as prevalence targets. A well-established system for brief intervention referrals may also help offset the fluctuation in demand for services at particular times of the year.

Formal referral systems to NHS smoking cessation services are necessary to increase the number of quit attempts that benefit from the most optimal form of support. However, Smokeline and www.canstopsmoking.com currently provide details of local services for those who may wish to self-refer.

When working with other services to ensure a referral and care pathway, services should ensure that associated staff are aware of the local NHS smoking cessation services, and coordinate and offer training (brief intervention training is available in Scotland as an accessible e-learning package – see Section 6), as well as seeking top level approval and support for the referral systems being developed. The Chief Executive Letter CEL14 (www.sehd.scot.nhs.uk/mels/CEL2008_14.pdf) may be useful as leverage for commissioners of services, or as a reminder of obligations.

Good practice: Increasing referrals

Referrals can be increased through:

- promoting brief intervention referrals within primary and secondary care, and more widely
- Keep Well and Equally Well projects and similar initiatives
- Smokeline or advertising Smokeline's number for details of services within an NHS Board area.

Case studies: Increasing referrals

NHS Grampian works to ensure a MAPLE (Multiple Access Points and Levels of Entry) system of entry to the service, with dedicated arms of the service, each with a distinct referral pathway to ensure smooth referrals and attracting smokers into services:

- community
- pharmacy
- workplace
- secondary care
- support for pregnant women
- support for young people
- support for adult mental health (via a smoking cessation specialist adviser).

Also, GPs are sent a smoking cessation reference tool, featuring a brief advice flowchart detailing local service information and detailing how each product should be used and associated contraindications.

NHS Lanarkshire has a referral pathway between the acute and community smoking cessation service. Clients who have been supported to stop smoking in hospital are contacted by the community team upon discharge and invited to attend a group or receive a home visit if required. These patients also receive a two-week supply of NRT upon discharge which allows them to continue with their quit attempt until they receive support from the community team.

Managing waiting times

Smoking cessation can be fraught with high demand at some times of year (typically January to March) and lower at others. Formal systems to support referrals, thereby increasing referral rates at off-peak periods during the year, may help to offset the peaks in demand at traditionally busy times.

Good practice: Managing waiting times

Possible peak times:

- New Year
- No Smoking Day
- post summer holidays.

Some issues to consider in the event of long waiting lists:

- provision of more groups and less 1:1
- more phone support
- devising procedures for clients who cancel repeatedly or do not turn up
- adhering to access agreements, e.g. six appointments over a three month period
- reducing staff annual leave in peak periods
- protocols for other staff (e.g. nurse bank trained staff) to fill in
- building in additional capacity to service planning
- marketing in quieter periods to promote smoking cessation at other times of year
- online booking systems in primary care
- electronic referral systems
- work with primary care to get central support initially on referrals to services
- reviewing job descriptions to enable maximum flexibility.

Staffing

Good practice issues: Managing staffing

- When considering the number of appointments feasible per specialist smoking cessation adviser, factor in administration time and travel time to appointments.
- An administrator should be factored into the service staffing.
- Bear in mind fixed term contracts or funding arrangements along with general funding and contractual issues.

Examples of useful policies and issues to be aware of when managing a smoking cessation service and its staff

- recruitment and selection; training of staff; letters to GPs; electronic referral pathways; lone worker policies; risk assessments; complaints procedure; SCI (Scottish Care Information) gateway referral processes.

Case studies: Staffing

NHS Forth Valley uses sessional staff within their specialist smoking cessation services. These staff work as health visitors, district nurses and practice nurses during the daytime, but have undertaken additional smoking cessation training in order to be able to focus on providing this sessional support in the evening, with dedicated time for this purpose. This professional background, plus their working knowledge of the area, helps to achieve high quit rates at one month follow-up.

NHS Western Isles' geographic location and dispersed population are major barriers in terms of service access. It has increased staffing levels to overcome this situation. In addition to the full-time coordinator post for the NHS Board area, one isle (Uist) has a part-time worker of three days per week, and another two (Lewis and Harris) share a part-time worker of three days per week, whilst another (Barra) has a part-time worker of 10 hours per week; this is in contrast to the initial stages of service development which only had a part-time coordinator post of three days per week covering the entire NHS Board area. As a result of this increased staffing, the increase in referrals quadrupled from the first quarter in one year to the first quarter the following year. They have also found that increased staffing has enabled them to reach young people and patients with health problems that may be caused or exacerbated by smoking such as diabetes.

Other resource issues

The following highlights good practice issues identified through case studies in Scotland for other specific resource aspects of commissioning including financial issues and administration.

Good practice: Resource aspects of commissioning

Financial aspects

Issues for financial consideration include:

- planning services and budget allocation
- recruitment and selection costs (and fixed term contracts/long-term contractual issues)
- training costs
- administration costs
- adequate provision for resources (including venues for smoking cessation support provision; CO monitors, tubes and calibration kits; laptops for staff; smoking cessation literature and promotional resources/incentives)
- funding arrangements and nature of funding.

Administration

Issues to consider when planning how the service will be administered include:

- who has overall responsibility within the NHS Board for this aspect of the service (whether it be the smoking cessation coordinator or someone else)
- the ISD national smoking cessation database
- the procedure for how records from the national pharmacy scheme will be incorporated into the ISD database
- archiving/storage of client records
- availability of a central phone number for taking referrals and allocating places in a smoking cessation intervention
- administration issues when the smoker is within the service which will include: referral, prescribing, inputting data, discharge, whether/how audit records are updated, letter generation, templates for first appointments and cancellations, discharge and follow-up at one, three and 12 months.

7.3 Scotland's smoking cessation services: Evidence

7.3.1 Quit attempts and one month quit rates made through Scottish smoking cessation services

Figure 8: Number of quit attempts made, and number 'self-reported' quit at one month follow-up 2006–2009

	Total number of quit attempts made	Number quit at one month	Percentage quit at one month*
2006	46,466	15,471	34%
2007 (revised)	44,019	15,309	38%
2008 (revised)	51,621	20,188	39%
2009**	69,882	26,485	38%

*Percentage quit at one month is calculated using the total number of quit attempts made in each year, minus (in the earlier years) records for which there existed no follow up data, as the denominator.

**Figures for latter part of the year and the 2009 total are expected to increase due to late submission of data/data recording, particularly for pharmacy records.

More detailed data can be accessed in each year's annual report, available on the Scottish Public Health Observatory website www.scotpho.org.uk

7.3.2 Analyses of effectiveness of Scottish smoking cessation services

An analysis³⁵ of the effectiveness of Scottish smoking cessation services noted the following:

- Services include formal group or individual sessions, pharmacy services, or remote services whose service delivery methods include a greater proportion of post, email, text and phone contact with less face-to-face contact; these services include the setting of a quit date and CO monitoring in addition to contact.
- The percentage of successful quits are lower in deprived groups than in more affluent groups. However, the larger volume of quit attempts made by clients from deprived groups means greater absolute numbers of successful quits, so SCSs in Scotland have been successful in reaching deprived communities.
- Being deprived, living in urban areas and having higher dependence on nicotine reduced the odds of quitting, but being employed or older increased chances.
- In those areas in which pharmacy services operated, they had higher reach.

It noted the following recommendations for service improvement:

- Attempts to improve the one-month quit rates (to be on a par with those of the English cessation services).
- Areas which may not extensively use services or interventions associated with significantly higher odds of cessation success (such as standard, 'closed' groups) should consider the introduction or expansion of such methods.

This analysis concluded by noting that the choices NHS Boards make are crucial to the success of the service. Service type, intervention type and pharmacotherapy used (especially groups, primary care services and varenicline which were most successful) have a large influence on success. It also notes that, in order to maximise reach and cessation success, high reach services must be carefully balanced with high intensity and high cessation success interventions, resulting in two different approaches that should be developed in different ways.

Another study⁶² in Scotland found:

- Both pharmacy and group support were effective and cost-effective.
- Older smokers, more affluent smokers and those very determined to quit were less likely to relapse, but relapse rates vary by model of treatment (higher in pharmacy services) and by smoker characteristics (age, affluence and determination to quit).
- Services are likely to be more successful if the clients were older and/or in poorer health.
- The group service was more effective than the pharmacy service (controlling for client characteristics), but costs more and is less cost-effective than the pharmacy service which is more accessible and has higher throughput.

This study concluded that smokers are more likely to quit in the short- and longer-term if they access group support, posing the question of why group support is currently not more widespread in the UK. Pharmacy, however, is more accessible and has higher throughput. Therefore, both types of intervention have a valuable role to play in cessation but consideration needs to be given as to what can be done to increase pharmacy success rates and to expand access to group-based services in order to increase cessation rates, particularly among deprived groups. The coexistence of both forms of support is required to provide comprehensive smoking cessation services, meet varying needs, and to maximise quit attempts and successful quitting, hence the relative strengths and weaknesses of both forms of support should be considered by service planners and commissioners in designing the service mix most appropriate to their population.

These results concur with a paper to review the evidence for the effectiveness of NHS intensive treatments for smoking cessation in preparation for NICE's public health programme guidance on smoking cessation services⁶³, in which two studies were cited which pointed to group interventions producing higher CO-validated quit rates at four weeks than 1:1 interventions. However, they concluded that as 1:1 interventions are also effective, and many clients express a preference for this form of intervention, they are a key component of the NHS smoking cessation services because they offer a choice. One type of smoking cessation intervention will not be suitable for all smokers and a variety of options should be available⁶⁴. Smoking cessation support should be accessible to smokers and flexible to the needs of different client groups⁶⁵.

Providing flexibility and choice and assessing the individual need of the smoker are key factors for implementing successful interventions, 'although local conditions will to some extent determine the most appropriate models of delivery'⁶³.

Summary of the effectiveness of Scottish smoking cessation services (SCSs)

- Analyses of Scotland's services show that both group sessions and pharmacy schemes are effective, but for different reasons (cessation success and 'reach' respectively).
- Intensive group interventions have low throughput, but a high success rate; pharmacy schemes have a lower success rate but higher throughput and higher cost-effectiveness; both have a role to play in an overall cessation strategy.
- Group interventions may produce higher quit rates than 1:1 interventions; however, 1:1 interventions should still be offered as they are still effective and may appeal to an individual's personal preferences.
- In addition to intervention type offered (service type, intervention and pharmacotherapy), cessation success is predicted by a number of other variables including: client age, socio-economic status and status of employment, living in an urban or rural area, self-reported nicotine dependence, motivation to quit, existing health conditions – all factors which planners and commissioners should be aware of.
- Offering a range of interventions is important to meet varying needs, and provide flexibility and choice, and to increase quit attempts and successful quitting.

8 Planning services in varied settings, for specific groups, and involving a range of staff

This section describes commissioning and service planning-oriented recommendations, good practice examples and case studies around providing smoking cessation services (SCSs) for specific population groups, in a variety of settings and involving a range of NHS and other staff. It should be read in conjunction with the *Helping smokers to stop* resource and Sections 1–6 of this resource which detail the standard and specific nature of the support expected to be provided. This does not include all the key groups and settings – only those with commissioning-specific recommendations.

8.1 Particular population groups, particular settings and key NHS staff

Different professional groups can play distinct but equally important roles to support service delivery to particular population groups. In general, their role involves the provision of brief advice and referral on to specialist cessation services. This section focuses on several different types of health professional, and includes examples of case studies that highlight the roles that key workers can play.

Recommendations for commissioning with key groups and within key settings

- a. Ensure that SCSs target, reach and effectively support minority ethnic and socio-economically disadvantaged communities, at least in proportion to their representation in the local population of tobacco users.
- b. Tailored advice and support should be provided, in particular for those from specific population groups (especially for those from minority ethnic and disadvantaged groups, pregnant women and hospital inpatients), in the language chosen by clients where possible, and in locations and schedules to suit them where circumstances would specify or where feasible. For example, these could include: arranging for home visits for pregnant women, offering support to those with complex social and emotional needs through substance misuse services, mental health services, youth and teenage pregnancy support, or offering workplace interventions.
- c. NHS SCSs should ensure that they can provide cessation support to hospitals including timely cessation support for patients waiting to be admitted to hospital or who are in hospital, and a fast-track referral system after discharge for patients who have tried to quit smoking in hospital. In addition, intensive SCSs should be provided for patients while in hospital, where appropriate and possible.

- d. NHS SCSs should ensure that they give pregnant women and women who are planning a pregnancy and women who are breastfeeding or who have an infant under 12 months, high priority in the planning, design and delivery of intensive smoking cessation services, with fast-track access to conveniently located and timed services, and that they attempt to meet the needs of disadvantaged pregnant women who smoke by involving them in the planning and development of such services.
- e. NHS SCSs should promote their services and make links with, ascertain demand for and/or offer outreach support to, and where practicable in, specific non-NHS locations such as workplaces (including NHS Scotland and Scottish local authorities) and prisons, subject to demand, and agencies that support those with complex and social and emotional needs (e.g. substance misuse services, youth and teenage pregnancy support, and mental health services). These should also ensure access to pharmacotherapies in line with local SCS protocols.
- f. SCSs should offer support to employers who want to help their employees to stop smoking and provide support on employers' premises where feasible, focusing in order of priority on SMEs, enterprises with a high proportion of employees on low pay, a high proportion of those from disadvantaged backgrounds and heavy smokers. These should be in line with the *NHS Health Scotland Commentary on NICE Public Health Intervention Guidance 5: Workplace health promotion – how to help employees to stop smoking* (NHS Health Scotland, 2007).
- g. Work with managers of workplaces, prisons, mental health, military or care institution settings to develop a policy, using *Smoke-free Scotland: Guidance on Smoking Policies for the NHS, Local Authorities and Care Service Providers*, and guidance from the Scottish Centre for Healthy Working Lives on workplace tobacco policy development, to ensure that effective SCSs are provided and promoted.
- h. Also in these settings (workplaces, including prisons, military and care institutions), work with managers to negotiate a smokefree workplace policy with employees or their representatives which should (where applicable): state whether or not smoking breaks may be taken during working hours and, if so, where, how often and for how long; direct people who wish to stop smoking to services that offer appropriate support, e.g. the NHS SCSs; implement the *NHS Health Scotland Commentary on NICE Public Health Intervention Guidance 5: Workplace health promotion – how to help employees to stop smoking* (NHS Health Scotland, 2007).
- i. Planners should be aware of the detailed recommendations contained within the *Scottish Perspective on NICE Public Health Intervention Guidance 23 on School-based interventions to prevent smoking* (available at www.healthscotland.com/scotlands-health/evidence/NICE.aspx), actively consider the importance of school-based prevention and cessation approaches for young people, and ensure that services link in appropriately with relevant organisations.

- j. In light of recommendations c–h above, NHS Boards’ smoking cessation coordinators should establish and maintain effective links between various services such as:
- local hospital care services in order to ensure a clear referral plan is developed and established between different parts of the NHS (if applicable) and timely cessation support provided for patients waiting to be admitted to hospital, who are in hospital or waiting to be discharged from hospital.
 - primary and secondary care to ensure that effective monitoring systems are set up for health professionals to have access to information (e.g. via the patient’s case notes, all records held in general practice and in hospitals) on current smoking status and most recent occasion on which advice was given to quit smoking, or encouragement to stay stopped given to an ex-smoker, the nature of that advice, and the patient’s response to that advice.
 - maternity services, and within maternity services (e.g. contraceptive services, fertility clinics, ante- and post-natal services), and any other outreach schemes (e.g. family nurse partnership) or agencies (e.g. youth and teenage pregnancy support, substance misuse services, or mental health services, which offer support to women with complex needs), to: identify additional opportunities for providing intensive and ongoing support; and ensure that health professionals use the many opportunities available to them (at various stages of the woman’s life) to offer advice on smoking cessation and on protection from passive smoking (second-hand smoke), and referral to a specialist SCS where appropriate.
 - managers of local workplaces, prisons, military establishments and care institutions for the development of policies and smoking cessation support provision including pharmacotherapies onsite.

8.2 Supplementary information

8.2.1 Particular population groups

When planning services, commissioners should be mindful of the legal duties placed on NHS Boards to promote equality and to eliminate discrimination within their service provision. Guidance on meeting the equalities duties, and good practice in delivering culturally competent services, is available at www.healthscotland.com/Equalities/index.aspx

Socio-economically disadvantaged individuals and communities

As specified in Section 4.2.1, when planning services, commissioners should be aware that depending on the characteristics of a region, deprivation may be at more of an individual than at a community level.

Good practice: Working with socio-economically disadvantaged groups

In widely scattered rural communities, where deprivation may be dispersed, this may have implications for service delivery and design, e.g. it can be more appropriate to target deprived groups through other routes/characteristics besides that of postcode.

People with disabilities

Good practice: People with learning disabilities

Commissioners and coordinators can work with learning disabilities teams locally to target this population group. Issues around accessibility and/or support provision via home visits are of particular importance with this client group.

Rural areas

Good practice: Working in rural areas

Issues to consider when working in rural areas include:

- telephone support provision
- phoning client in advance to confirm attendance or availability for appointment, reducing unnecessary travel
- policies for lone working
- clustering appointments geographically to avoid extra travel time between appointments.

Black and minority ethnic groups

Good practice: Black and minority ethnic groups

Given the varied tobacco use of different minority ethnic groups, in designing or delivering any intervention it is important to research, and become familiar with, the characteristics of the target population. This should include gaining an understanding of different forms of tobacco use (in addition to manufactured cigarettes) and the prevalence of their use in the local population.

Pregnant women

Good practice: Pregnant women

A mapping exercise of the extent and nature of smoking cessation support in pregnancy in Scotland⁴⁸ compared current practice with existing guidance and recommendations, highlighted examples of promising practice, and provided learning points for the development and delivery of cessation support in pregnancy. These 47 learning points fall under the headings of: behavioural support approaches; staffing and services structures; targeting, identification and referral; pharmacotherapy support; training and awareness raising; and recording monitoring and national data. Given the entrenched nature of smoking, particularly for pregnant smokers who have not managed to quit, training for all staff who come into contact with pregnant smokers is also necessary rather than relying purely on specialist staff to provide the support. Locally delivered PATH training on this topic is available (and other locally developed training may also be available depending on the area); see Section 6 for more details.

8.2.2 Specific settings

Hospitals/secondary care

A Cochrane review concluded that 'there are potential benefits of smoking cessation advice and/or counselling given by nurses to patients', especially when that advice is intensive and provided by nurses whose main role is smoking cessation/health promotion, and that 'advice and support from nursing staff could increase people's success in quitting smoking, especially in a hospital setting'⁶⁶.

In addition to in this resource, recommendations for staff within secondary care on how to carry out interventions with patients are detailed in the accompanying *Helping smokers to stop* resource.

Further information: Smoking cessation service for people having elective surgery

This commissioning guide from NICE (available at www.nice.org.uk/PH010) may prove a useful resource for commissioners on commissioning and provision of an effective SCS for people having elective surgery.

Good practice: Hospital-based support

A mapping exercise of the extent and nature of smoking cessation support in secondary care in Scotland⁶⁷ compared current practice with existing guidance and recommendations, highlighted gaps and examples of promising practice, and provided learning points for the development and delivery of cessation support in secondary care which 'could form a basis for agreeing a set of quality standards'. These 27 learning points fall under the headings of: service development; management and staffing; referral within the hospital; provision of pharmacotherapies; referral to the community; training; and monitoring.

The mapping exercise found that the support of a specialist smoking cessation adviser working from within or in close proximity to the hospital is a prerequisite for a successful service. Services relying only on frontline staff providing brief advice and referral to community-based SCSs generate only a small number of referrals.

CEL 14 (2008), the letter from the Scottish Government's Director General – Health, entitled Health Promoting Health Service: Action in Acute Care Settings (www.sehd.scot.nhs.uk/mels/CEL2008_14.pdf) and the mapping exercise/audit relating to smoking cessation support in secondary care, provide some recommendations for SCSs for this client group.

Training in brief interventions aimed at health professionals 'Raising the Issue of Smoking' has been developed by PATH, and further details are available in Section 6.

Case studies: Commissioning aspects of hospital smoking cessation support

A variety of service models exist (e.g. in terms of access or referral pathways to services within and between primary and secondary care, and service locations in primary and secondary care – including some hospital-based smoking cessation services in Scotland).

NHS Greater Glasgow and Clyde's service for hospital inpatients includes NRT and smoking cessation service information in the hospital prescribing formulary.

NHS Grampian, as part of the development of pre-operative smoking cessation in partnership with GPs and outpatient consultants, has smoking cessation included on the standard proforma in pre-assessment clinics.

NHS Greater Glasgow and Clyde's service for hospital patients ensures that:

- hospital inpatients making a quit attempt receive shared care consisting of behavioural support provided by hospital smoking cessation advisers and community advisers, pharmacotherapy of two weeks' NRT on discharge, and up to 12 weeks' NRT via community pharmacy
- the smoking cessation team of staff can deliver the service in any of the seven acute hospital sites via a standardisation of systems, ensuring continuity in service provision
- awareness of the smoking cessation service, and how to manage patients with acute nicotine withdrawal, is enabled by detailing the support provided in patient pathways, copies of which are inserted into the British National Formulary (BNF) when they are distributed to medical staff
- data collection following national guidelines originates in the acute setting and is transferred to the community service for completion
- activity regarding referrals and quit outcome is reported by directorate to the lead nurses concerned.

Workplaces

Good practice: Workplace support

A mapping exercise of the extent and nature of smoking cessation support in workplaces in Scotland⁶¹ found that the factors which seemed critical to the effectiveness of services in the case studies presented were: a commitment to ongoing provision of support; services which were tailored to the needs of staff; services which were linked to other health improvement topics; a range of methods of raising awareness of support available; and No Smoking Day activity.

Smoking cessation services are offered in workplaces in a variety of formats such as local SCSs being actively promoted within workplaces including onsite work, links between SCSs and Healthy Working Lives to increase awareness and encourage uptake among workplaces, and training for employees to provide smoking cessation support to their colleagues.

8.2.3 Specific professional groups

Different professional groups can play distinct but equally important roles to support service delivery to particular population groups. In general, their role involves the provision of brief advice and referral on to specialist cessation services. This section focuses on several different types of health professional, and includes examples of case studies that highlight the roles that key workers can play.

Primary care

Brief advice on smoking cessation from doctors increases the likelihood that the smoker will quit and remain quit 12 months later⁶⁸. This has been found in a systematic review of randomised trials, in which abstinence was determined at least six months post-intervention, concluding that this is the case for both hospital doctors and GPs, although the particular circumstances in which advice is delivered is clearly different for each.

Such advice (brief opportunistic advice for smokers attending a consultation for another condition) can increase quit rates by a further 1–3% over and above the unassisted or baseline ‘background’ quit rate of 2–3%^{14, 68}. More intensive advice from a doctor and/or providing follow-up support may result in higher quit rates⁶⁸. In addition, those who are medically referred to SCSs are more likely to be successful than self-referrals⁶⁹.

In addition to in this resource, recommendations for staff within primary care on how to carry out interventions with patients are detailed in the accompanying *Helping smokers to stop* component of this guide.

Good practice: Primary care

Primary care is a key source of referrals to SCSs. GPs should be aware of all referral options to SCSs as well as how to provide brief interventions. Helping smokers to quit is a key part of the primary care remit, and payments are currently made to practices for this under the Quality and Outcomes Framework (QOF).

Maternity services

Smoking during pregnancy is an established cause of a large number of conditions harmful to both the mother and unborn child (described in Section 4.2.3). Due to their role and skills in dealing with mothers-to-be, midwives are uniquely positioned to offer interventions and to support pregnant women in quitting. Tailored training in this area is available through PATH in the form of a course entitled ‘Raising the Issue of Smoking During Pregnancy’ (see Section 6).

Mental health staff

As described in Section 4.3.5, psychiatric patients and settings have a higher level of smoking than in the general population and individuals with psychiatric problems can also demonstrate greater nicotine dependency. Hence, within mental health settings – particularly residential settings – all staff have the opportunity to contribute towards the reduction of health inequality experienced by this group.

The unique needs of mental health service users mean that often the staff best placed to offer an intervention are those who routinely work with them. In recent years, research and pilot projects have been carried out which have led to the development of specific training in 'Raising the Issue of Smoking with Mental Health Service Users' (see Section 6).

Dentistry

Dentistry is well-placed to provide smoking cessation support given the large proportion of the population who visit a dentist for regular check-ups including teenagers and pregnant women who are entitled to free dental care.

Tobacco use is associated with an increased risk for oral disease, including oral cancer and periodontal disease⁷⁰. Dental professionals can provide smoking/tobacco cessation support to tobacco users who present for dental care. A review⁷⁰ demonstrated that this provision of support increased the likelihood of 12-month follow-up cessation in comparison with standard or no support. Although the major evidence for effectiveness in dental settings to date comes from smokeless tobacco users rather than for cigarette smokers, it is reasonable to assume the effects will be similar for both types of tobacco use.

Case study: Dentistry

Links with community dental services

NHS Borders smoking cessation staff have developed strong links with their oral health promotion team. They have focussed on supporting dental staff to raise awareness of the impact of smoking on oral health, and have developed training on smoking cessation brief advice in a dental setting. The training:

- increases knowledge and awareness of tobacco use and the impact of smoking on oral health
- introduces the concept of brief advice and the rationale for it
- increases confidence about raising the issue of tobacco use with dental clients
- explains how to refer dental clients on to the smoking cessation service.

The training incorporates input from a Consultant in Maxillofacial Surgery from the Edinburgh Dental Institute on the physical impact of smoking, focussing on oral cancer and the prevalence of such diseases. This is followed by brief advice training from the NHS Borders smoking cessation coordinator on raising the issue of smoking within a dental setting. The half day training session, delivered in dental locality meetings, ensures the involvement of the whole dental team from receptionists to dentists. The training, which has evaluated well, resulted in a steady number of referrals from community dental teams to smoking cessation services. In addition, the issue of smoking is being raised in a non-medical context and also to patients who may otherwise be physically well and not in contact with other clinical services. The training is planned to be followed up on an annual basis and is intended to be rolled out to private dental practices as evening sessions during 2010.

Pharmacy-based smoking cessation services

Pharmacy-based smoking cessation services have undergone development over recent years. Due to their locations in communities and hours of opening, they offer an accessible and flexible option to potential quitters.

National pharmacy scheme

A national community pharmacy scheme was launched in 2008 in which 12 weeks of structured behavioural support (ordinarily 1:1) and NRT is offered in accordance with national pharmaceutical service specifications. Although it is acknowledged that the level of support is not currently of the same level as that provided by group support⁶², as specified in Section 2.3, the service offered is expected to aspire to be delivered to the same standards as those of the specialist NHS smoking cessation services.

The aim of the scheme is to help smokers stop successfully by providing extended access to smoking cessation support and pharmacotherapy through the NHS. Pharmacy services are required to provide the smoking cessation service in accordance with service specifications provided by Scottish Ministers to NHS Boards, and disseminated by NHS Boards to public health service providers.

Further information: Specific information on pharmacy scheme

Details of this national community pharmacy scheme are available in the Scottish Government's NHS Circular PCA(P)(2008)17 *Additional Pharmaceutical Services Minor Ailment Service and Public Health Service Directions, Service Specifications and Payment Arrangements* – available at [www.sehd.scot.nhs.uk/pca/PCA2008\(P\)17.pdf](http://www.sehd.scot.nhs.uk/pca/PCA2008(P)17.pdf) – which specified revised Directions for Additional Pharmaceutical Services for 2008–2009.

Updates to this are made available on the Scottish Government website and additionally sent to Chief Executives of NHS Boards, and the Chief Executive and Director of Practitioner Services of NHS National Services Scotland. Further details are available from Community Pharmacy Scotland (www.communitypharmacyscotland.org.uk), from www.psd.scot.nhs.uk or from the local NHS Board Consultant in Pharmaceutical Public Health.

Pharmacists and their support staff are encouraged to proactively seek out clients such as those with cardiac or respiratory disease, clients from disadvantaged neighbourhoods, pregnant women or young people.

Service standards, training and record-keeping details are included in the Directions. Pharmacists are expected to operate within the national service specification and in accordance with any local prescribing guidance, formularies and protocols. The national service specification includes the setting of a quit date, assessment for NRT, attendance for further supplies of NRT and ongoing support over 12 weeks (normally on a weekly basis) provided by the pharmacists or support staff, recording of smoking status, and follow-up.

Record-keeping is in line with the national minimum dataset for national monitoring purposes and included within the data for the relevant NHS Board within which the service falls. Clients may be referred to other NHS Board smoking cessation services according to needs and local patient pathways. Further details are available from Community Pharmacy Scotland or from the local NHS Board Consultant in Pharmaceutical Public Health.

Other pharmacy support

Other pharmacists/pharmacies, those not part of the national pharmacy scheme, may also provide support which is akin to that of brief intervention support.

Case study: Pharmacy

Links with pharmacy services

NHS Borders has had a pharmacy service for a number of years which has ensured strong links between the smoking cessation service and the pharmacy service. The SCS supports cross referral between pharmacy, practice nurses and the SCS itself to ensure that a client is offered the service which best suits their needs. A local agreement is in place between pharmacy services and the local SCS/health promotion department in which all pharmacy staff are required to attend the local intensive support training offered by the SCS/health promotion department and thereafter the annual updates.

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Appendix: Key source material

Source 1: NHS Health Scotland Commentary on NICE Public Health Implementation Guidance no.1 – (NICEPHIG1 Brief interventions and referral for smoking cessation in primary care and other settings) (NHS Health Scotland, 2007)

As part of its role in promoting and supporting evidence-informed action for health improvement in Scotland, NHS Health Scotland produced *Commentaries on NICE Public Health Guidance* (now known as *Scottish Perspectives on NICE Public Health Guidance*). The process involves consideration of the evidence and recommendations presented in the NICE Guidance, in the context of policy and practice in Scotland.

This commentary presents recommendations on brief interventions and referral for smoking cessation in primary care and other settings. The commentary only considers whether brief smoking cessation interventions, rather than more intensive interventions, are effective at encouraging individuals to quit smoking; it presents recommendations on brief interventions and referral for smoking cessation in primary care and other settings.

Source 2: NICE Public Health Guidance 10 – Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities (2008)

The guidance is for NHS and other professionals who have a direct or indirect role in – and responsibility for – smoking cessation services. This includes those working in local authorities and the community, voluntary and private sectors. This guidance superseded *Guidance on the use of nicotine replacement therapy (NRT) and bupropion for smoking cessation (NICE technology appraisal guidance 39)*.

Source 3: NICE Public Health Guidance 26 – ‘How to stop smoking in pregnancy and following childbirth’ (2010)

This Guidance is for NHS and other commissioners, managers and practitioners who have a direct or indirect role in, and responsibility for, helping women to stop smoking in pregnancy and following childbirth. It complements, but does not replace, other NICE guidance cited above.

Source 4: *Smoking Cessation Guidelines for Scotland 2004 Update* (NHS Health Scotland and ASH Scotland, 2005)

This document was commissioned by NHS Health Scotland and ASH Scotland to take account of the experience of the first few years of delivering these services, and the evidence base in smoking cessation. It replaced *Smoking Cessation Guidelines for Scotland* published in 2000. This updated document made recommendations for the organisation and implementation of clinical interventions to promote smoking cessation in Scotland. It was intended for the use of health professionals and health planners at all levels. It provided a blueprint for the development of systems for ensuring that all health professionals were able to play an effective role.

Source 5: *Smoking Cessation Update 2007: Supplement to the 2004 Smoking Cessation Guidelines for Scotland* (NHS Health Scotland and ASH Scotland, 2007)

This paper updated the guidance and developments presented in the *Smoking Cessation Guidelines for Scotland: 2004 Update* (NHS Health Scotland and ASH Scotland, 2005) above.

Additional policy documents of relevance to those involved in planning or providing specialist smoking cessation services in Scotland include:

- Scottish Executive (2004). *A Breath of Fresh Air for Scotland (2004): the tobacco control action plan* [Edinburgh: Scottish Executive] – the current overarching tobacco policy document – www.scotland.gov.uk/Publications/2004/01/18736/31541
- Scottish Government (2008). *Scotland's Future Is Smoke-Free: A smoking prevention action plan (2008)* [Edinburgh: Scottish Government] – another policy document which sets out a programme of measures designed specifically to dissuade children and young people from smoking and to protect them from tobacco – www.scotland.gov.uk/Publications/2008/05/19144342/0

Scottish smoking cessation and tobacco control policy documents should be considered in the context of the following Scottish Government publications:

- Scottish Government (2007). *Better Health, Better Care: Action Plan (2007)* [Edinburgh: Scottish Government] – www.scotland.gov.uk/Publications/2007/12/11103453/0
- Scottish Government (2008). *Equally Well: Report of the Ministerial Task Force on Health Inequalities (2008)* [Edinburgh: Scottish Government] www.scotland.gov.uk/Publications/2008/06/25104032/0 (Part 1) www.scotland.gov.uk/Publications/2008/06/09160103/0 (Part 2) *Equally Well: Report of the ministerial task force on inequalities* (Scottish Government, 2008) – this Task Force was set up to tackle the inequalities in health that would otherwise prevent Scotland from achieving the Government's overall purpose of sustainable

economic growth, supported by increased healthy life expectancy, and it identified several priority areas for action to reduce inequalities such as focusing on a child's early years and addressing the inter-generational factors that risk perpetuating Scotland's health inequalities from parent to child. Recommendation 51 in *Equally Well* is that it 'should be a key priority within the Government's smoking strategy that NHS Boards and their local partners act to prevent young people in deprived communities from smoking, and to provide more effective support to smokers in those communities to quit'.

Other relevant documents for smoking cessation context and service implementation:

- CEL 14 (2008) (letter from The Scottish Government's Director General – Health), entitled Health Promoting Health Service: Action in Acute Care Settings www.sehd.scot.nhs.uk/mels/CEL2008_14.pdf
- Scotland's developing *Early Years Framework*, referred to in *Early Years and Early Intervention: A Joint Scottish Government and COSLA Policy Statement* (2008) see www.scotland.gov.uk/Resource/Doc/215889/0057733.pdf
- the NHS Health Scotland-commissioned mapping exercises on pregnancy, secondary care and workplaces (2008) www.healthscotland.com/documents/2665.aspx and www.healthscotland.com/documents/2664.aspx and www.healthscotland.com/documents/2958.aspx respectively.
- external evaluation of the NHS Health Scotland/ASH Scotland Young People and Smoking Cessation Pilot Programme (NHS Health Scotland, 2006) see www.healthscotland.com/documents/1381.aspx
- Comparing Models of Smoking Treatment in Glasgow: Final Report (March 2009) see details on www.healthscotland.com/documents/3266.aspx
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