Local Stop Smoking Services: service delivery and monitoring guidance 2011/12

Key point summary

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_125389

Overview

This summary document highlights the key points within the 2011/12 Local Stop Smoking Services: service delivery and monitoring guidance and identifies how this differs from the 2010/11 version.

The annually published Department of Health (DH) guidance aims to provide both commissioners and providers of local stop smoking services with evidence-based and best practice guidance as well as information regarding the mandatory DH monitoring requirements. As in previous years, the 2011/12 version is split into three sections; Commissioning, Delivering and Monitoring, with additional appendices.

The projects being undertaken by the NCSCT Community Interest Company (NCSCT CIC) and the NHS Centre for Smoking Cessation and Training (NCSCT) are also indicated throughout the document.

Commissioning

Key points

The commissioning section covers three core areas; identification and referral of smokers, methods of stopping smoking, and stop smoking interventions.

Identification and referral of smokers

- All smokers should be advised to stop smoking and offered evidence-based support, regardless of whether they express a desire to stop.
- Smoking cessation has been linked to the potential for teachable moments meaning that all healthcare professionals (HCPs) can have a positive impact on a smoker's decision to stop.
- The systematic provision of very brief advice and routine referral of smokers to stop smoking service providers would be best written into all provider contracts supported by appropriate training and established formal referral systems.
- All local HCPs (e.g. practice nurses, community pharmacies, district nurses, midwives and health visitors) and social care professionals should be aware of the AAA model for the provision of very brief advice and routinely refer smokers to the local stop smoking service provider/s. A simple guide to aid the delivery of very brief advice is available on the Smokefree Resource Centre (http://smokefree.nhs.uk/resources).
- Formalised systems such as electronic referrals or paper-based referral paperwork enable this identification of referral sources and areas where referral rates could be improved.
- It is not recommended that service providers are remunerated for referrals as often this activity is remunerated through Quality, Innovation, Productivity and Prevention (QIPP), the Commissioning for Quality and Innovation (CQUIN) schemes and Quality and Outcomes Framework (QOF) payment schemes.

Methods of stopping smoking

- There are a number of methods of stopping smoking that smokers commonly use.
- Latest research has shown that medication bought over the counter is no more effective than when a smoker makes an unassisted quit attempt.
- In contrast, medication supplied by a Healthcare Professional doubles the likelihood of stopping.
- The most effective method is a combination of behavioural and pharmacological support such as that provided by local stop smoking services. This method quadruples a smoker's chance of stopping.
- Stop smoking services are now well established and deliver substantial numbers of successful four-week quitters. Service providers support around a quarter of all successful quits per annum and are a key element of the Government's overall tobacco control plan.
- Smokers attempting to stop without additional support have a success rate of about 25% at four weeks (for carbon monoxide (CO) validated quits) and a success rate of about 35% at four weeks (for self-reported quits). Therefore to show an effect, services must achieve success rates in excess of these.
- Priority groups for services to target include smokers with a mental disorder, pregnant smokers, routine and manual (R/M) smokers, prisoners and certain black and minority ethnic (BME) communities.
- To support service design, configuration and improvement, efficient and accurate data systems are recommended.

Additional note on stop smoking services:

- It is important to note that despite their success, services shouldn't be regarded as the main driver for reducing smoking prevalence, and should sit within an overall tobacco control programme forming a part of wider action to reduce local smoking prevalence.

Stop smoking interventions

- NICE programme guidance on smoking cessation recommends the following stop smoking interventions as being cost effective:
  - brief interventions
  - individual behavioural counselling
  - group behaviour therapy
  - pharmacotherapies – Nicotine Replacement Therapy (NRT), Zyban (bupropion) and Champix (varenicline)
  - self-help materials
  - telephone counselling and helplines
- As in previous editions the 2011/12 guidance for local stop smoking services includes evidence-ratings for interventions, a summary of which can be found at the back of this summary document (Appendix 1).
- All interventions should adhere to the quality principles which are based on previous guidance, changes in the evidence base and the latest understanding of 'best practice'. The quality principles are provided on page 28.
- A minimum of 85% of all reported four-week quitters should be biochemically validated.
- Nicotine replacement therapy (NRT), Zyban (bupropion) and Champix (varenicline) should all be made available as a first line option.
- Stop smoking advisers should be trained to NCSCT standards and achieve NCSCT certification.
- It is important to provide a choice of interventions accompanied by supporting information regarding the relative chances of success of each intervention type. Commissioners also need to balance the need for widely accessible services and high efficacy rates.
- It is therefore important to note that smoking cessation interventions delivered by advisers for whom this is not their main job e.g. in GP practice, pharmacies and dental practice, are in general less effective than interventions delivered by staff who are specifically employed to work in smoking cessation and frequently deliver stop smoking support. However, settings such as GP practices, pharmacies and dental surgeries remain a valuable resource, often providing clients with greater choice and flexibility, since they are often available in places and at times when specialist provision may be unavailable.
- Quality principles for financial practice are provided on pages 35 and 36.

Key additional content / changes within the commissioning section

- The section has undergone a general re-ordering and additional content is provided regarding referral sources, particularly in relation to primary care and mental health, alcohol and substance misuse services (pages 12 and 15).
- Additional information has been added regarding the QoF (page 17) and the QIPP programme (page 18).
- A greater explanation of the methods of stopping smoking and the support provided by stop smoking services has been included (pages 20 – 21).
- Further guidance regarding sources of data and intelligence can be found on page 23.
- A summary of the evidence ratings within the document has been added (pages 26 – 27).
- Information regarding the NHS Centre for Smoking Cessation and Training (NCSCT) has been updated (pages 29 – 30).
- A brief summary of the routes to quit pilots is included (page 32 and Annex D (pages 113 – 114)).
- A brief section on service models and Payments by Results is included (pages 32 – 33).
- The commissioner and provider checklists have been moved to Annex A (pages 100 – 103) and Annex B (pages 104 – 106) of the document.

Delivery

Brief interventions and very brief advice (pages 39 – 40)

Key points

- All health and social care workers should systematically deliver very brief advice to smokers at every opportunity.
- Simple and easy to use formal referral systems should be in place.
- Treatment outcomes should be routinely fed back to referrers.

Additional content / changes

- Practical suggestions for maximising referrals have been added (page 40).

Intervention types (pages 41 – 45)

Key point

- Pragmatic definitions of the various intervention types are provided to support data recording.

Additional content / changes

- The evidence rating for rolling groups has changed from an 'I' to a B.

Delivering interventions

Key points

- All interventions should be delivered by advisers trained to NCSCT standards and follow the quality principles on page 28 of the guidance.
- Currently services follow the abrupt model within which a smoker sets a quit date with a trained adviser and smokes not one puff after that date. The NHS Centre for Smoking Cessation and Training (NCSCT) has developed a Standard Treatment Programme for the delivery of the abrupt model www.ncsct.co.uk/resources/downloads/NCSCT_STP_ed2.pdf

Assessing nicotine dependence

Key points

- The Fagerström test for nicotine dependence (FTND) provides a quantitative measure of nicotine dependence and is the most widely used.
- The full Fagerström test and the shortened version (Heaviness of Smoking Index) are provided on pages 46 and 47.

Biochemical markers

Key points

- A minimum of 85% of all self-reported quitters should be biochemically validated either by carbon monoxide (CO) testing or cotinine.
- The most cost-effective and least invasive option is CO testing.
- A reading of 10 ppm or under at the four-week follow-up point can be counted as a validated quitter, unless the client self-reports smoking despite achieving a low reading.
- All stop smoking advisers need to have access to a CO monitor at every consultation.
- Systems should be in place to ensure that CO monitors are calibrated according to the manufacturer's instructions and checked regularly thereafter.
- A client may self-report that they are not smoking but, on testing, exhibit abnormally high expired CO levels. In such cases, they should be given advice about possible CO poisoning.

Pharmacotherapy

Key points

- Stop smoking medicines currently approved by NICE are NRT bupropion (Zyban) and varenicline (Champix).
- All stop smoking pharmacotherapies should be offered on prescription to any smoker who is motivated to quit. Many areas use patient group directions (PGDs) and/or voucher systems to make this possible.
- All pharmacotherapy should remain available for at least the duration recommended by the product specification and patients should be able to access approved stop smoking medicines simply and easily.
- Pharmacotherapies should be available for more than one treatment episode. For example, if a client using Champix relapses during a quit attempt, providing they are adequately motivated to attempt to stop again they should be able to begin a new course of Champix if this is assessed to be the most appropriate medicine for that client.
- Where a client relapses during a quit attempt and does not wish to begin a new treatment episode no further pharmacotherapy should be provided until such time that the client is motivated to make another quit attempt.
- In the case of NRT, local prescribing arrangements should consider the need to balance the total number and cost of prescription charges incurred by the client and the need for structured and frequent face-to-face contact.

Additional content / changes

- It should be noted that at the time of drafting the guidance, the Nicorette QuickMist 1 mg mouthspray had not been launched however this has occurred since and is now available as part of the NRT range.
- Additional information regarding preloading / cutting down has been included (page 59).

Effect of cessation on medications

Key points

- This is a new section within the guidance.
- It is crucial that advisers establish any medicine/s that clients are currently taking at the first session before stopping smoking and that they liaise with prescribers as appropriate to ensure that any required alterations to the dosage are made by the prescriber and are being monitored.
- If the person subsequently relapses and starts smoking again, then the prescriber should again be informed as drug metabolism will increase and the dosage will need a further review.

Priority population groups

Key points

- Smoking cessation interventions tailored for people from disadvantaged groups may be slightly more effective than generic interventions aimed at these groups. However, it is unlikely that tailored interventions alone have a significant impact on the social gradient in smoking prevalence. It is important to ensure that stop smoking service providers are easily accessible by people from these groups and that they are encouraged to use them.
- These groups are; routine and manual smokers (R&M), pregnant smokers, smokers with a mental health disorder, smokers in secondary care settings, prisoners, substance misusers, black and minority ethnic groups, children and young people.

Additional content / changes

- An overview of the NICE Public Health Guidance 26: How to stop smoking in pregnancy and following childbirth has been inserted (pages 71 – 74).
- Additional content has been added to the teenage pregnancy section (page 74).
- The mental health section has been extensively revised (pages 75 – 82) and emphasises the importance of identifying all clients with a mental health problem and any medication that they may be currently taking.
- The secondary care section has been streamlined (pages 83 – 84).

Repeat service users

Key points

- Smokers often need several attempts before stopping successfully. Anyone who has made a previous, unsuccessful, quit attempt should therefore be encouraged to access their local stop smoking service.
- Quit attempts should draw on experiences from previous attempts to stop, and should bear in mind factors that contributed to previous relapses.

Monitoring

Key points

- Formal data is collected through more detailed, quarterly data collections (ROCR/OR/0028/009). Since the beginning of 2008/09, primary care trusts (PCTs) have submitted returns electronically directly to the NHS Information Centre (IC), whereas previously this happened through strategic health authorities (SHAs).
- There are no substantive changes to the quarterly monitoring and reporting process for 2011/12
- At the end of the monitoring period (a quarter plus six weeks), PCTs have a further four weeks to submit data to the IC in the case of Quarters 1 to 3 and five weeks in the case of Quarter 4 data. This means that, at the end of the quarter, SHAs have a total of 10 weeks to submit returns for Quarters 1, 2 and 3 and 11 weeks to return Quarter 4.
- Revisions of previous quarters (to allow for late data) are permitted in the case of Quarters 1, 2 and 3 but not in the case of Quarter 4.
- It is essential that services adopt strict criteria when deciding who to include in their monitoring return, and the four-week quit status of a client. These criteria also need to be applied consistently. When recording the numbers of smokers entering treatment and the numbers successfully quit at four weeks, it is essential that all services adhere to the definitions given in Annex C of the document (pages 107 – 112).
- The purpose of the data monitoring system is to monitor and evaluate the effectiveness and reach of the services. It is not a mechanism for counting all people who have stopped smoking in a locality, nor is it a prevalence measure. For this reason it should not include quits that have not resulted from structured stop smoking interventions delivered by stop smoking advisers.
- Before submitting quarterly data, service leads should examine their data. If they find outlying data they should carry out the exception reporting procedure, which is explained in more detail on pages 98 and 99 of the document.
- Annex I (pages 121 – 122) provides a gold standard monitoring form identifying all of the mandatory data requirements.

Additional content / changes

- The data returns timetable has been updated (page 95).
- Further recommendations regarding additional data collection have been suggested (page 96).

Annexes

Additional content / changes

- **Annex A** –The checklist for commissioners has been revised and appears in table format (pages 100 – 103).
- **Annex B** – The checklist for providers has been revised and appears in table format (pages 104 – 106).
- **Annex C** – Provides all relevant definitions (pages 107 – 112). Slight amendments have been made to the spontaneous quitter definition (page 109).
- **Annex D** – an overview of the Routes to Quit model has been added (pages 113 – 114).
- **Annex E** – useful contacts have been updates (pages 115 – 116).
- **Annex H** – an example evaluation proforma has been added to support the testing of innovative approached locally (pages 119 – 120).

Melanie Chambers
Senior Delivery Manager
NCSCT Community Interest Company
April 2011

delivery@ncsct.co.uk
www.ncsct.co.uk

Appendix 1
Summary of the 2011/12 Evidence ratings

Evidence ratings of recommendations

Every recommendation in the delivery section of the guidance has a rating to show the extent to which it is evidence-based. This is based upon the Scottish Intercollegiate Guidelines Network (SIGN) rating system, an internationally recognised scale to rate research evidence. The SIGN rating system was recently adapted for smoking cessation guidance by the New Zealand Guidelines Group (NZGG), and the same evidence ratings are used here. These are as follows.

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

In order to grade the evidence in this guidance, reviews of published research were conducted by members of the guidance development group. The process included identifying relevant systematic reviews and primary studies of smoking cessation interventions. Particular attention was paid to reviews conducted to inform NICE guidance and primary studies conducted in the UK, due to their relevance for English stop smoking services. Evidence gradings are updated annually in line with the guidance to take into account the findings of any new studies.

Table 1: Summary of evidence ratings

Section	Evidence rating
Very brief advice	A
Behavioural support	A
Intervention types	
One-to-one support	A
Couple / family support	I
Closed group support	A
Open (rolling) group support	B
Drop-in support	I
Telephone support	
Proactive	A
Reactive	B
Text-based	B
On-line support	B
Assessing nicotine dependence	
Quantitative approach	A
Biochemical markers	
Carbon Monoxide	A
Cotinine	A
Increasing quit rates through lung function / spirometry	I
Pharmacotherapy	
Nicotine Replacement Therapy	A
Combination therapy	A
Preloading / cutting down	B
Bupropion (Zyban)	A
Varenicline (Champix)	A
Smoking populations	
Routine and manual smokers	B
Pregnancy	B
Nicotine Replacement Therapy in pregnancy	C
Teenage pregnancy	✓
Smoking and mental health disorder	B
Secondary care	A
Prisoners	C
Substance misuser	C
Black and minority ethnic groups	B
Children and young people	I
Prevention and tobacco control	B
Relapse prevention	I
Repeat service users	✓

Other interventions and products that are either not recommended or are currently not evidence based are also included in the delivery section and are again summarised below.

Table 2: Effectiveness of other interventions

Some evidence of effectiveness but not recommended
Rapid smoking
Cytisine
Insufficient evidence – currently not recommended
Allen Carr
Nicobrevin
NicoBloc
St John's Wort
Glucose
Lobeline
Exercise
Evidence of no effectiveness – not recommended
Hypnosis
Acupuncture
Acupressure
Laser therapy
Electrostimulation
Anxiolytics
Incentives / competitions