Review of NHS smoking cessation services
Advisory group report
June 2014
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Executive summary

Scotland has a strong history of legislating and implementing good and effective tobacco control policy. These policies have included smoke-free legislation in 2006, increasing the age of sale of tobacco to 18, new laws on the sale and display of tobacco products and the first tobacco retail register in the UK. In March 2013, a new tobacco control strategy – Creating a Tobacco-Free Generation – was launched. In this strategy, NHS Health Scotland was asked to lead on a review of NHS specialist smoking cessation services.

In Scotland, NHS Boards are funded to provide national specialist smoking cessation services. There is also a national community pharmacy smoking cessation service and a national telephone helpline (Smokeline). The focus of this review was to examine specialist services, although it was accepted that this would also include considering aspects of the pharmacy service too.

An advisory group chaired by Professor Linda Bauld was convened for the review, and research was commissioned by NHS Health Scotland from Ipsos MORI Scotland to examine a number of key aspects of current service configuration and delivery.

The research was able to draw on findings from a secondary analysis of routine monitoring data collected by cessation services in Scotland. This was funded by The Scottish School of Public Health and carried out by Information Services Division (ISD, part of NHSScotland) in collaboration with researchers from the Universities of Stirling and Bath.

Five NHS Boards were selected for case study research. Interviews were conducted with key stakeholders and focus groups or paired depth interviews conducted with smoking cessation advisers. The research also involved an online survey of NHS staff (smoking cessation advisers, coordinators, and other operational staff) to identify training needs, but the survey also captured practitioners’ views on how service provision could be improved. The full Ipsos MORI Scotland Smoking Cessation Services Review report can be accessed at www.healthscotland.com/documents/23527.aspx

The recommendations contained in this report from the Smoking Cessation Services Review Advisory Group are therefore largely, but not exclusively, derived from these two separate studies outlined above. It is worth noting that both of these studies took place before the recent increase in use of e-cigarettes so e-cigarette use was not explored as a discrete topic.
Discussion and recommendations are included in the report section on ‘Improving the effectiveness of smoking cessation services’. The recommendations are grouped under three themes:

- Reducing variation in outcomes and improving consistency between services.
- Increasing reach and success, particularly with priority groups.
- Improving processes within services and training for staff.

- Reducing variation in quit outcomes and consistency between NHS Boards considers the following:
  1. National branding of NHS smoking cessation services.
  2. Improving access to varenicline and combination NRT.
  3. Offering a variety of behavioural support options, tailored to client needs.
  4. Validating quit rates and using feedback from smokers, which ought to be used to inform service development.
  5. Improving referral systems and maximising links between a smoke-free NHS and smoking cessation services.

- Increasing reach and success, particularly with priority groups, considers:
  1. Identifying clients and maintaining motivation
  2. Community development and third sector approaches to client engagement
  3. Increasing options for smokers
  4. Young people
  5. Specific settings
  6. Pregnant women

- Improving processes within smoking cessation services and training considers:
  1. Follow-up
  2. Carbon monoxide (CO) monitoring
  3. Training

A summary of the key recommendations is given at the end of this report on p. 26.
Report

Introduction

In March 2013, the Scottish Government launched a new tobacco control strategy – *Creating a Tobacco-Free Generation*. As a key action in this new strategy, NHS Health Scotland was asked to lead a review of NHS specialist smoking cessation services.

The benefits of a comprehensive range of tobacco control measures on individual, social and societal issues related to smoking are well documented.\(^1\)\(^2\)\(^3\) Since 1999, Scotland has implemented tobacco control measures designed to address its poor health record and shift attitudes to smoking. Consequently, Scotland is now seen as a world leader in legislating and implementing strong and effective tobacco control policy. In particular, these policies include smoke-free legislation in 2006, increasing the age of sale of tobacco to 18, new laws on the sale and display of tobacco products and the first tobacco retail register in the UK. Scotland is one of the few countries worldwide with a comprehensive network of smoking cessation services offering a programme of behavioural support and pharmacotherapies free of charge.

Smoking cessation services are available in every NHS Board in Scotland. These services were originally set up from 1999 and consist of nationally funded NHS specialist smoking cessation services (with £9 million allocated per annum for these) and the community pharmacy smoking cessation scheme. There is also a national telephone helpline (Smokeline) and brief intervention delivery and referral into services from a range of health and other professionals. No formal review of NHS specialist smoking cessation services has taken place since their establishment, although recent evaluations of the national community pharmacy smoking cessation service and Smokeline have taken place.

Only an estimated 1 in 10 smokers makes a quit attempt through smoking cessation services in Scotland each year. The success of services – as measured in routine data by quit rates – differs by client characteristics (in particular by deprivation group) and between services with varying levels of performance. In addition, there are high rates of ‘lost to follow-up’, even at one month, and gaps between self-reported and CO-validated quit rates.

Commissioned research

An advisory group chaired by Professor Linda Bauld was convened to review NHS smoking cessation services. To inform the review, a research report was
commissioned by NHS Health Scotland from Ipsos MORI Scotland to examine a number of key aspects of current service configuration and delivery.\(^{a}\)

The aims of the research commissioned to inform the review were to:

- assess the effectiveness of smoking cessation services in Scotland
- explore the factors that influence variable practice and outcomes between services
- assess current and future needs for smoking cessation training
- identify opportunities for future service development and improvement

The research was able to draw on findings from a secondary analysis of routine monitoring data collected by cessation services in Scotland which was funded by The Scottish School of Public Health and carried out by ISD in collaboration with researchers from the Universities of Stirling and Bath.\(^{4}\)

In addition, five NHS Boards were selected for case study research and interviews with key stakeholders were conducted in each of these. Focus groups or paired depth interviews were also conducted with smoking cessation advisers in each NHS Board. The research also undertook an online survey of NHS staff (smoking cessation advisers, coordinators, and other operational staff) involved in delivery of smoking cessation services across Scotland. The main purpose of the survey was to identify training needs, but the survey also captured practitioners' views on how service provision could be improved.\(^{5}\)

The recommendations contained within this report by the Smoking Cessation Services Review Advisory Group are therefore largely, but not exclusively, derived from these two separate studies.

**Background service context and structure**

NHS smoking cessation services provide support to nationally agreed standards, delivered by those with nationally recognised training. This includes:

- specialist smoking cessation services that offer structured behavioural support delivered in groups or 1:1, together with licensed pharmacotherapy (nicotine replacement therapy, varenicline or bupropion). This support is delivered by specially trained staff (normally smoking cessation advisers) in a variety of NHS and non-NHS settings
- the national community pharmacy smoking cessation service, which complements the specialist smoking cessation services and provides a course of advice and nicotine replacement therapy (NRT) over a period of up to 12 weeks.

\(^{a}\) Full membership of the group is included as Appendix III
Services are expected to collect data about their clients and the extent to which these clients are successful in stopping smoking. This data collection is done locally at NHS Board level but feeds into the national smoking cessation database managed by ISD.

In general, across most NHS Boards, the intensive behavioural support provided by specialist smoking cessation services achieves higher success rates for clients than the community pharmacy service.

**Figure 1: Quit attempts made versus successful outcomes pharmacy/non-pharmacy: Scotland 2009–12**

Source: NHS Smoking Cessation Service Statistics (Scotland) (revised data)\(^6\)

However, as smoking cessation services have developed, improved self-report quit rates have been recorded in routine data for both specialist smoking cessation services and pharmacy services.

Generally, referrals to any NHS smoking cessation service (specialist or community pharmacy) occur by self-referral, referral from health professionals and from Smokeline. Community pharmacy services are highly accessible to smokers and can handle a greater throughput than specialist services; however, service provision is different and the service may attract a different clientele.\(^7\)

**National targets**

Targets for pregnant women, deprived groups and young people have been in place since the establishment of services following initial UK and Scottish tobacco control policy papers.\(^8\)\(^9\)\(^10\) These prevalence targets were superseded by Health
Improvement, Efficiency, Access and Treatment (HEAT) targets from 2008. Smoking cessation services have a specific role in contributing to HEAT targets.

From April 2008 to March 2011, NHS Boards were set the HEAT 6 target to support 8% of each Board’s smoking population to successfully quit (at one month post-quit date) over the three-year period. From April 2011 to March 2014, NHS Boards were set the revised HEAT target to deliver universal smoking cessation services to achieve at least 80,000 successful quits [equivalent to 7.5% of each Board’s smoking population] (at one month post-quit) including 48,000 in the 40% most deprived within-Board Scottish Index of Multiple Deprivation (SIMD) areas over the three-year period. NHS Boards have performed well, with the majority of NHS Boards exceeding this target before 31 March 2014.

From April 2014, the Scottish Government set a new HEAT target which builds on this inequalities focus but over the more sustained term of 12 rather than four weeks. It requires NHS Scotland to deliver universal smoking cessation services to achieve at least 12,000 successful quits, at 12 weeks post-quit, in the 40% most deprived within-Board SIMD areas (60% for island Health Boards) over one year, ending March 2015.

The HEAT targets have been instrumental in ensuring NHS smoking cessation services have become more delivery-focused. Despite nationally agreed standards for smoking cessation and recognition that services vary according to geography and local need, there is wide variation in performance in one month quit rates by individual Health Boards. The secondary analysis of ISD data found that despite an overall four-week quit rate of 38% for smokers accessing services, key factors affecting differences between areas were: the type of behavioural support offered; the type of pharmacotherapy provided; the setting (pharmacy or non-pharmacy) where support is offered and whether the service was located in a rural or urban area. On average, services in rural areas had higher quit rates, but this is at least in part driven by the finding that services treating fewer smokers have higher quit rates. There is thus a balance to be struck between throughput and outcomes. The recommendations below address both the need to support more smokers, and the need to maximise the chances that each of these smokers will stop.

Inequalities

Smoking is a key factor in health inequalities in Scotland and over 13,000 deaths (around a quarter of all deaths) and 56,000 hospital admissions each year are estimated to be attributable to smoking. The annual cost to NHSScotland of treating smoking-related diseases is estimated to be more than £323 million and may be higher than £500m.

Adults in the 15% most deprived areas of Scotland are considerably more likely than those in the rest of Scotland to say that they are current smokers. Figure 2 below shows a trend of generally decreasing smoking prevalence rates from the 10% most
deprived to the 10% least deprived areas. Around one in ten adults living in the 10% least deprived areas of Scotland smokes, compared to around two-fifths of adults (39%) in the most deprived areas.

**Figure 2: Percentage of respondents who smoke by Scottish Index of Multiple Deprivation**

![Figure 2: Percentage of respondents who smoke by SIMD](image)

The need to reduce rates of smoking in the most deprived communities has been recognised by Scottish Government in the most recent HEAT target, which ended on 31 March 2014 and also the new HEAT target in place from 2014–15. The most recent data shows that 23,803 (20.6%) quit attempts were made by smokers living in SIMD 1 (most deprived) compared with 3,359 (2.9%) made by smokers living in SIMD 10 (least deprived). This is encouraging as it shows that services are effectively reaching clients from communities where smoking rates are higher. However, examining one-month quit outcomes by SIMD reveals that the most deprived areas (SIMD 1–2) have the lowest percentage quit rates and the least deprived areas (SIMD 9–10) have the highest percentage quit rates. This mirrors findings from a number of studies that show that although smokers from more deprived communities and backgrounds are just as motivated to quit and just as likely to try and stop as their more affluent neighbours, they are less likely to be successful in their quit attempts.

Although SIMD is generally used as a marker of deprivation, this approach does have its limitations, particularly in rural areas. As these locations are usually heterogeneous, an area-based measure is not an accurate identification of materially
deprived individuals. However, no other approach stands out as a clearly better alternative.\textsuperscript{16}

Therefore, if smoking cessation services are to have a positive impact on addressing the inequalities gap, then they need to be targeted to reach disadvantaged smokers. Consideration needs to be given to service availability and design, ensuring additional support and more tailored, easily accessible and flexible services are offered. This would help to improve the outcomes as well as the engagement of deprived groups. Generic untargeted interventions may contribute to reducing adult smoking but may increase inequalities in smoking. In contrast, interventions targeted at deprived groups may result in a higher relative uptake of services which can more than compensate for their relatively lower quit rate and therefore have a positive equity impact.\textsuperscript{3 17}

In addressing inequalities, it is also important to understand that smoking cessation services will only have a modest impact on reducing prevalence at the population level. Reviews that have assessed the impact of different tobacco control measures on reducing inequalities show that those measures based on legislation, taxation/fiscal policy or regulation are the most likely to result in improved health and reduced inequalities. Therefore, smoking cessation services need to be delivered alongside these wider population-based policies and be integrated with them\textsuperscript{3 17} and should also link with wider tobacco control activity at local level, e.g. by engaging with local authorities and CPPs.

All recommendations with regard to inequalities in this report will need to align with the Scottish Government’s health inequalities impact assessment (HIIA) developed to support the tobacco strategy. This includes issues around engagement with minority ethnic groups and their use of tobacco.

**Ethnic minorities**

Ethnicity data is collected on the national smoking cessation database and in 2013 the completion rate for the ethnicity field was 91.9%. ‘White British’ was recorded in 88.6%, ‘White Other’ 2.4% and ‘Unknown’ in 8.1% and ‘Other Ethnic Group’ in 0.9%. Ethnic groups in Scotland have lower adult smoking prevalence rates than the British-born population (Indian 19%, Pakistani 1%, African, Caribbean or Black 17\%\textsuperscript{18})

From the 2011 Census we know that the number of people from ethnic minorities in Scotland had increased considerably since 2001.\textsuperscript{19}

The smoking cessation database uses the same ethnicity classification and an analysis of cessation service use by ethnic group is being undertaken. This is complicated by the small samples used in the Scottish Health Survey and comparing smoking cessation database and census data and will be completed during 2014.
Improving the effectiveness of smoking cessation services

Previous research has shown that smokers are, on average, four times more likely to be successful in their quit attempt if they access support and pharmacotherapy from smoking cessation services when compared with willpower alone. A smoker accessing any NHS cessation service is, therefore, improving their chance of stopping. However, it is apparent from national monitoring and the secondary analysis work mentioned previously that outcomes vary between individual services and intervention ‘type’ (who delivers it, where, and in what form). A priority is to maximise the chances of success for every client who attends a cessation service in Scotland, while also reaching as many smokers as possible. In order to do this, the review recommends action in three main areas:

- Reducing variation in outcomes and improving consistency between services.
- Increasing reach and success, particularly with priority groups.
- Improving processes within services and training for staff.

The recommendations in this report should be read in conjunction with the Ipsos MORI (IM) research report.

Reducing variation in quit outcomes and consistency between NHS Boards

The following are suggested for national implementation to improve consistency within and between NHS Boards and to achieve improved abstinence rates from smoking for those who use the services.

1. National branding of NHS smoking cessation services

At present, each NHS Board has at least one branded NHS smoking cessation service. Some Health Boards also have distinctive branding for each Community Health Partnership (CHP). The lack of a uniform brand for NHS services is confusing for potential service users and efficiency would be improved without separate branding within NHS Board areas.

National branding would help to establish a strong unifying identity for smoking cessation delivery in Scotland by creating a uniform presence, and a recognisable brand across the country. Common practices, processes and services could be established while still maintaining a strong local presence and identity. A number of wider activities identified for the NHS in the tobacco control strategy could also be supported and driven forward usefully under the umbrella of a national tobacco-free brand. This might include smoke-free NHS grounds as well as developing plans for smoke-free buildings in mental health and prison settings.

A single recognisable national brand also provides a simpler interface for self-referral (single webpage, one national phone and email contact). This would simplify...
awareness-raising with potential service users by promoting a single service brand with local access. It could also address the duplication of provision between local contact numbers and the national telephone support line, Smokeline. Additionally, as NHS 24, the operators of Smokeline, will assume responsibility for the supporting website www.canstopsmoking.com/ during 2014, they could be requested to lead on the development of a national web portal, e-referral and interactive social media to engage with clients who may prefer these forms of access and support. A national brand would improve efficiency by streamlining processes within NHS Boards to ensure work is not duplicated across CHPs while maintaining its valued local ownership and presence.

The need to maintain the high visibility of NHS smoking cessation services through regular social marketing campaigns is important. Research has shown that such campaigns have a direct impact on the number of calls and referrals into services. A key action for the Scottish Government is to ensure that smoking cessation retains a high profile, and promotion of a single branded entity simplifies national marketing and also supports national opportunities such as No Smoking Day and other campaigns.

2. **Improving access to varenicline and combination NRT**

Current access to effective pharmacotherapies is variable. In particular, varenicline use among service clients is low in Scotland (9%) compared to England (26%), even though the secondary analysis of smoking cessation data showed that clients receiving varenicline were more successful at one month post-quit date (65%) than clients receiving single NRT (35%) or combination NRT (39%). Varenicline use varies across NHS Boards from less than 10% to 34% of all quit attempts and is frequently used as a second line option for quit attempts.

- It is recommended that as part of a unified national smoking cessation service, national protocols are developed to improve the prescribing of pharmacotherapies; in particular, varenicline and combination NRT.
- National prescribing protocols should also ensure that a range of NRT products, including combination NRT (using more than one product concurrently), is available as an option for prescribing to all service users.
- The IM research found evidence of variable processes and timescales for clients to receive pharmacotherapies once in touch with services. National prescribing protocols need to ensure these are improved to expedite and streamline the service user experience.
- National prescribing protocols need to ensure that NHS Boards improve access to varenicline, including provision through pharmacies and allowing smokers to use it as a first line option. The revised smoking cessation service specification for the national community pharmacy scheme includes a sample patient group direction (PGD) for varenicline. National training by NES is available for pharmacists and this should improve prescribing of varenicline through
independent pharmacy prescribers and opportunities to develop shared care with specialist services for behavioural support.

- Quit outcomes are maximised when smokers receive behavioural support as well as pharmacotherapy. Referral to specialist support services needs to be improved to maximise uptake of behavioural support and reduce prescribing of pharmacotherapy without specialist support. More active engagement with GPs and use of systems such as e-referral would help in this regard.
- NHS Boards need to analyse their local prescribing data to identify usage, inform local planning and identify any gaps in provision.

3. **Offering a variety of behavioural support options, tailored to client needs**

The vast majority of clients in Scotland access 1–1 behavioural support. However, monitoring and observational research shows that group support (both open and closed groups) is more effective. The secondary analysis of ISD data shows that clients receiving 1–1 support had the least successful quit rates at one month (35%) whereas 50–60% of clients receiving group support quit, depending on the type of group.4

- Group support (including rolling groups) should be offered and encouraged initially over 1–1 or other types of support. Although smaller numbers make this a more difficult option for rural communities, there are opportunities to use natural groupings, such as workplaces, to encourage group support in rural areas.
- Links between different forms of support within Health Boards should be improved (for example, between pharmacy and specialist services). Efforts should be made to try and provide the best form of behavioural support to address a client’s needs.
- All NHS Boards should make use of, and record, ‘shared care’ (where a client is supported by both specialist and pharmacy services) on the national smoking cessation database so that this can be monitored and its effectiveness evaluated.

4. **Validating quit rates and using feedback from smokers, which ought to be used to inform service development**

CO monitoring is an essential part of service monitoring, a useful tool to lead into discussion on smoking, and a feedback mechanism to maximise motivation to engage with services and quit. CO monitoring provides an ideal opportunity to regularly validate and record service users’ smoking status and provide feedback and motivation (see also ‘Improving processes’). CO monitoring should be a mandatory requirement for all smoking cessation services.

- Practice with regard to routine CO monitoring must be improved. Scottish Government policy leads should re-emphasise the importance of regular validation, recording and monitoring of CO status to both specialist and pharmacy
services. The importance of CO monitoring has been consistently emphasised in the revised pharmacy service specification to be implemented from 1 July 2014.

- Regular CO monitoring should also be used to provide feedback to service users as affirming their quit attempt and maintaining their motivation.
- Formal mechanisms should be developed that ensure client feedback is obtained and built into ongoing practice. Different means of obtaining service user feedback should be considered, such as exploring options of gaining feedback electronically or whether this could be captured as part of the long-term follow-up.
- Mechanisms should be developed to capture the views of those who drop out of services prematurely and smokers who contact or are referred to services but do not subsequently attend (DNAs).

5. Improving referral systems and maximising links between a smoke-free NHS and smoking cessation services

As previously indicated, there is a clear need to build relationships between cessation services and primary care. This is also the case between acute care and cessation services. CEL 01 (2012), Health Promoting Health Service: Action in Hospital Settings advocates greater access to cessation support in acute settings and more integrated and continuous care when moving in either direction between primary and secondary care. This should increase both uptake and success rates among more deprived communities by bringing smokers into contact with specialist support at times of greatest motivation (i.e. acute or planned health episodes). As a first step, simple and straightforward systems should be in place to enable speedy referral.

- Referrals from primary care to specialist support services should be improved. Increased use of e-referral systems and incentivisation through a locally enhanced service (LES) or a quality and outcomes framework (QOF) should be considered.
- Care pathways, both pre- and post-admission, should be developed for acute settings. These pathways should ensure that NHSScotland’s smoke-free policy is communicated to patients prior to admission, record smoking status, offer symptomatic relief to smokers for nicotine withdrawal and follow up with a brief intervention and onward referral.
- Acute staff should receive appropriate training in smoking cessation, particularly in relation to care pathways outlined above.
- Senior managers in hospitals should actively promote a smoke-free NHS and ensure that care pathways for smokers are embedded in staff practice and training.
- Specialist smoking cessation staff should be available in hospitals to provide training for acute staff and to support smokers (including NHS staff).
- There is a need to raise awareness and build better support for smoke-free NHS grounds among staff, patients and the general public. The rationale for smoke-
free NHS grounds needs to be better communicated to the general public and at local level all patients, visitors and NHS staff need specific information through a range of media. Use of existing policies such as no tobacco use when identifiable as NHS staff (i.e. in uniform or wearing an NHS badge), infection control and timekeeping may be helpful in controlling smoking and smoking breaks for NHS staff and promoting smoking cessation. See also the suggestions made above at 1. ‘National branding of NHS smoking cessation services’, above.

**Increasing reach and success, particularly with priority groups**

Specialist smoking cessation service support should be focused on increasing the number of people quitting in priority groups. Pregnant women, young people, people with mental health problems, prisoners, and those living in disadvantaged areas, where as many as four in ten adults can be smokers, need to be reached and supported to stop smoking.

Services should be tailored to the specific needs of local communities, focusing on the factors that are likely to motivate people to quit and helping to overcome those barriers that are likely to hinder progress. They will need to consider how they attract and engage with their clients and sustain their motivation so that they maximise their chances of a successful quit attempt.

1. **Identifying clients and maintaining motivation**

   - Services need to ensure that the interventions offered are attractive to potential users. They will need to understand the specific needs of their target audience and ensure that their approach is tailored to engage this audience. This may include consideration of piloting novel and innovative approaches such as financial incentives to see if this increases uptake.
   - Similarly, more proactive engagement with clients will be required so that they can be supported and reengaged if they relapse.
   - Regular CO monitoring and recording should be a core part of service delivery, particularly as a motivational tool for clients as outlined above.

2. **Community development and third sector approaches to client engagement**

   - Services need to consider different strategies that meet the needs of local communities. As part of this process there will be opportunities to work in partnership with third sector organisations that will have good local knowledge and relationships with their communities. Closer engagement with community groups and third sector may help in relation to reaching and supporting clients from the most deprived communities.
3. Increasing options for smokers

Harm-reduction approaches have the potential to reach smokers who might not otherwise access cessation services. Recommendations on these approaches can be found in recent NICE guidance and the Addendum on tobacco harm-reduction available at www.healthscotland.com/documents/4661.aspx

Harm-reduction involves smokers cutting down their cigarette consumption before quitting, ideally with licensed nicotine products. It may also involve continuing to use these products in the longer term to prevent relapse to smoking. Temporary abstinence with the use of licensed products is also part of tobacco harm-reduction. There are also unlicensed nicotine containing products (e-cigarettes or vapourisers) that an increasing number of smokers and ex-smokers are using in the UK. However, there is currently limited evidence to date on their quality, safety and efficacy, and they are not currently regulated. Although the limited evidence suggests that they are likely to be less harmful than smoking, there is no evidence available on their long-term use. Specific details on each are available in Appendix II.

Emerging observational evidence suggests that e-cigarettes are as effective as unsupported nicotine replacement therapy in supporting smokers to stop but there is still a range of unanswered questions about such devices. Engaging with tobacco harm-reduction approaches and adapting to the rise in e-cigarette use are both important current challenges for smoking cessation services.

- Services should consider introducing a cutting down to quit option for clients who find it difficult to stop abruptly. This would involve supporting smokers to gradually reduce their cigarette consumption over a number of weeks (normally up to six weeks) with the view to setting a quit date and achieving abstinence from smoking.
- They should also provide advice, information and reassurance on the use of licensed nicotine containing products (such as NRT) for temporary abstinence, and for use in the longer term to prevent relapse.
- Services should not refuse access to behavioural support for clients who are using electronic cigarettes. Services can only recommend currently licensed products in view of their robust assurances on safety, quality and efficacy. E-cigarette users should be encouraged to switch to licensed products. However, if the smoker is not prepared to do so and is at risk of relapse to smoking, they should still be able to access support from the smoking cessation service. This should occur within the context of working towards complete abstinence from smoking.

If and when an e-cigarette product becomes licensed, protocols to recommend them and support clients to use them should be developed. However, this will need to take into account the costs and benefits of their availability via NHS
prescription versus the ethical implications of these products being produced or potentially owned by the tobacco industry.

4. Young people

Young people have historically had the lowest use of smoking cessation services. This is probably due to the dynamic nature of smoking in this age group which differs from adult smoking patterns and is frequently linked with the use of other substances such as alcohol and cannabis. There is a general awareness that services on offer at the moment are not ideal for this group. Further work needs to be done to assess demands and needs for services for young people. Young people do not tend to consider lifestyle behaviours in isolation; therefore a more holistic approach to risky behaviours is required.

- As an action from the 2013 tobacco control strategy, a Youth Commission has been tasked with considering key prevention measures for young people in the future. However, it is anticipated that they will also make recommendations on smoking cessation services for young people and identify new ideas for consideration by services to improve engagement with this sector.
- The IM research report recommended that a peer education system should be introduced to train young people to deliver brief intervention to their peers. A Scottish pilot study to implement and evaluate the ASSIST peer education programme in two Health Board areas is due to commence later in 2014.
- Investment in prevention efforts should not detract from ongoing support and resource for smoking cessation services. Research has shown that one of the key determinants of a young person starting to smoke is whether their parents and others around them smoke. It is therefore important that services continue to be there to support adults to stop in Scotland.

5. Specific settings

Services that are effective in the general population should be expanded to include priority groups such as mental health inpatients and prisoners.

Under current smoke-free legislation, there is an exemption for designated rooms in inpatient psychiatric hospitals/units. The tobacco control strategy identified an action for mental health services to ensure that indoor facilities are smoke-free by 2015.

In addition, smoking in cells in a prison is exempt under current legislation. The tobacco control strategy identified specific actions for prisons to progress in line with other developments across Scotland. This includes NHS Boards working closely with their local prison(s) to develop plans by 2015 that set out how indoor smoke-free prison facilities will be delivered.
The advisory group considered there was potential interest to move this forward with smoke-free NHS grounds and under an all-encompassing brand for tobacco-free delivery (see ‘National branding of smoking cessation services’).

6. Pregnant women

Smoking during pregnancy is the largest single preventable cause of disease and death to the fetus and infants, accounting for a third of perinatal deaths. Reducing the numbers of women smoking in pregnancy is key to improving both child and maternal health. The Maternity Care Quality Improvement Collaborative (McQIC) is part of the Scottish Patient Safety Programme run by Healthcare Improvement Scotland and oversees the activity of the maternity, paediatric and neonatal workstreams. Its overall aim is to improve outcomes and reduce inequalities in outcomes by providing a safe, high-quality care experience for all women, babies and families. A key area of activity for McQIC focuses on the processes of care related to the identification, referral and management of pregnant women who smoke.

All pregnant women are offered CO monitoring at booking with an automatic referral system (opt-out rather than opt-in). These strategies should ensure that a greater number of pregnant women who smoke are referred on to smoking cessation services and are encouraged to give up smoking.

- Full implementation of the McQIC programme should be pursued to ensure that all pregnant women are offered CO screening at booking and smokers are automatically referred to cessation services.
- For those women who refuse referral but continue to smoke, a tailored package of care should be offered, consistent with McQIC recommendations.
- Services receiving referrals for pregnant women should continue to prioritise these cases and support women to stop smoking at any stage in pregnancy and into the post-partum period.
- Services should promote the importance of smoke-free homes to pregnant women and their families.
- Self-help materials (consisting of information on the risks of smoking and effective methods to stop) for pregnant women should be available and accurate. This should include updating the existing Fresh Start resource by NHS Health Scotland.

Improving processes within smoking cessation services and training

There are a number of ways that existing processes within services can be improved to better meet the needs of clients. Recommendations to improve these are set out here, including how follow-up procedures can be adapted to achieve better outcomes.
1. Follow-up

There is a need to address the poor follow-up rates across Scottish services. As giving up smoking is challenging, there is natural attrition throughout the process. However, it is important that services maintain contact with their service users and continue to support and motivate them for the duration of their quit attempt. The HEAT target in place from 2014–15 puts greater responsibility on smoking cessation services to follow up quitters at 4 and 12 weeks. Due to the relatively high resource required to undertake long-term follow-up and the practical difficulties of conducting this at 12 months, it has been agreed that this will be undertaken on a national basis with a representative sample to derive a Scottish figure.

• NHS Boards should consider piloting a range of processes such as email and text messaging to improve follow up at 4 and 12 weeks and enable reengagement.

Following a report from a short-life working group recommending that 12-month follow-up of a representative sample of former clients should be undertaken on a national basis, Scottish Government is in the process of commissioning 12-month follow-up from NHS 24. This should be progressed as a matter of urgency.

2. CO monitoring

CO monitoring has been previously discussed in this report as part of validation of quit attempts. It is worth emphasising that it plays an essential role in service monitoring, providing an ideal opportunity to regularly validate and record service users’ smoking status as well as providing feedback and motivation (see also 4. ‘Quit rate validation’). CO monitoring should be a mandatory requirement for all smoking cessation services.

• All clients making a quit attempt through pharmacy and non-pharmacy services should be seen face to face at four-week follow-up and offered CO monitoring. This is recommended in the revised pharmacy service specification and should be done within the 4–6 week window of validation, consistent with the Russell standard.27
• CO monitoring is important in both validating self-reported quits and maintaining motivation by affirming the progress the quitter has made towards becoming smoke-free. Tobacco policy leads in Scottish Government should therefore re-emphasise the importance of CO monitoring and encourage all smoking cessation services to regularly take and record CO readings from their clients. Additionally, there is already a strong emphasis on regular CO monitoring within the revised pharmacy specification and in the McQIC programme detailed above.
3. Training

In advance of Scotland’s smoke-free legislation in 2006, NHS specialist smoking cessation services experienced increased investment and a period of expansion which continued until 2008. To support the growth of NHS smoking cessation services there was a need for a trained and competent specialist workforce.

Partnership Action for Tobacco and Health (PATH) – a partnership between Scottish Government, NHS Health Scotland and ASH Scotland – was established in 2002. PATH led on a number of developments for stop-smoking services across the areas of training, data collection, evaluation, prevention and cessation. Training standards were developed and most recently updated in 2009.28 These outlined the skills and knowledge required for four partially sequential standards, rising from level A–D; C/D being the required level for specialist stop-smoking support. Levels C and D consisted of academically accredited training modules in stop-smoking support developed in partnership with Glasgow Caledonian University.

Training for specialist smoking cessation staff is funded by Scottish Government, but in 2012 the decision was made to move towards developing a training specification and to tender for a supplier. As a result, Ipsos MORI were asked to include a training needs analysis as part of their review to help to establish future training needs for specialist smoking cessation advisers. Key findings and recommendations from the Ipsos MORI training needs analysis were as follows:

- Only 61% of those who deliver specialist services to clients have received in-depth smoking cessation training. It is recommended that NHS Boards should investigate and ensure that all specialist smoking cessation advisers have received in-depth high-quality training in line with the national smoking cessation guidelines.

- The need to maintain continuing professional development should be recognised both by the individual and by employers. It is recommended that NHS Boards should ensure that staff have regular opportunities to access refresher and update training to ensure continued personal and professional development and competency. These might include updates on developments in pharmacotherapies and other new developments as they arise, e.g. e-cigarettes and harm-reduction.

- The standard of training and delivery of pharmacy providers of the smoking cessation service was variable. To support the issuing of the revised pharmacy service specification, NES has reviewed and revised the online pharmacy training and organised face-to-face training opportunities in all NHS Board areas, in advance of the introduction of the new specification. The revised pharmacy specification includes a patient group direction (PGD) for varenicline, and pharmacists will require to be trained before they can prescribe it. It is
recommended that improved training opportunities for pharmacy technicians are available, whether these are locally provided by NHS Boards or online, and these may also prove useful for other health professional such as dentists. All pharmacy staff delivering the service should also attend suitable revision and update training sessions to ensure continued personal and professional development and competency.

Respondents to the survey were asked to consider the ways that smoking cessation may change and to consider what skills and knowledge would be required in the future. There was a wide range of responses and no issues stood out clearly.

**Wider workforce training issues**

Following these findings from the Ipsos MORI report, a half-day workshop to discuss workforce training issues was held with NHS Boards’ Smoking Cessation Coordinators. This was held specifically to inform the recommendations of this review, and focused on the future training needs for specialist smoking advisers but also discussed wider workforce issues.

The main issues discussed were as follows:

There is a need to refresh our thinking about the current workforce from all stages. NHS Boards raised the issue of difficulties in getting staff released to access training. It was important that the limited time available for training was used effectively by ensuring that generic health behaviour change training was offered with relevant knowledge ‘add-ons’ to ensure that staff do not repeat that element of training. Courses also need to be adapted to be specific to the environment staff work in and to fit the timescales available.

The table below shows three suggested levels for the wider workforce who may have the opportunity to give advice to smokers when they come into contact with them.

Very brief advice would consist of a passing opportunity to have a supportive conversation primarily to signpost a smoker on to services. Brief advice would still consist of a short, supportive conversation, but would include some knowledge of the evidence; e.g. midwife in discussion with pregnant women or a cardiac rehab nurse discussing smoking with a recovering patient. Specialist advice would include more in-depth knowledge, ability to advise on pharmacotherapy, etc. and health behaviour change/motivational interviewing skills.
There was also recognition of another level of stakeholders who have the ability to sponsor and influence local tobacco strategies, e.g. Directors of Education, hospital managers, professional leads, non-executive directors of NHS Boards, councillors, etc. They have the potential to be significant local enablers and it is important to work/build relationships with these stakeholders.

In order to meet the ambitious goals of the national tobacco strategy it was felt that there was a need for a significant amount of training with the wider workforce to ensure that all those that came into contact with smokers were able to raise the issue of smoking.

**Specialist smoking cessation adviser training**

When discussing the future specialist smoking cessation workforce and how services would be delivered, coordinators felt that the majority of smokers would be signposted to the pharmacy smoking cessation service. They considered that specialist smoking cessation services are likely to become more focused on inequalities and targeted at delivering to priority groups. Services are likely to be tailored to support each individual quit attempt and to develop approaches such as cutting down to quit, in order to maximise a client’s chance of remaining abstinent from smoking. Some NHS Boards are considering taking a more holistic approach and incorporating other lifestyle factors to develop a more person-centred approach to understanding and tackling individual health priorities. It was agreed that demand for specialist training would still be needed in the future, but the number of staff
requiring this may not be large. It was important that this was still available and a pragmatic approach to providing this was required in the future. Following the findings from the Ipsos MORI report and this further consultation with service coordinators, recommendations for training include the following:

- The Scottish National Training Standards should be reviewed and updated. These were last updated in 2009. Standard levels are probably satisfactory but the content of the standards should be updated to improve implementation and to better reflect new evidence since the last update.
- The training programme for specialists should use a blended learning approach to develop both knowledge and skills. This could consist of an online platform supported by face-to-face skills development. Online training can be used to acquire and test knowledge, followed by skills development/practical experience.
- NHS Boards should make use of existing training provision, including health behaviour change/motivational interviewing.
- Training for specialists needs to be more practical in the future, both in terms of length and regularity of training offered and for participants to learn from those with practical service experience. Consideration also needs to be given to the access needs of advisers in more remote and rural locations.
- Training must also reflect the needs of local smoking cessation services to avoid the unnecessary duplication and expense of local areas developing separate training. Smoking cessation coordinators suggested that a system of shadowing and mentoring of practice could achieve similar results to the currently accredited observed simulated clinical examination (OSCE) which was felt to be expensive and less suited to local implementation.
- An alternative or additional option for staff development may be to consider a vocational qualification over a longer period of time, e.g. SVQ qualification, which could provide transferrable career development.
- Future planning should include an appraisal of possible suitable training options from providers both within and outside Scotland.

Given the findings of the IPSOS Mori training needs assessment and consultation with service coordinators, it is clear that an ongoing programme of training for specialist smoking cessation service staff is urgently required. The Scottish Government should consider options, develop a new specialist training specification and tender for this service as soon as possible. The new training needs to be accessible to all NHS Boards in Scotland.
Conclusion

In concluding this report it should be noted that at the first meeting of the advisory group the decision was made to focus on NHS smoking cessation services. Cost-effectiveness and user experience research were both discussed but it was agreed that these were both separate areas of work that would require additional funding and therefore are outside the scope of this report. Similarly, it must be noted that both studies that the recommendations in this report are based on took place before the recent increase in use of e-cigarettes, so e-cigarette use was not explored as a discrete topic.

The key recommendations contained within this report are summarised overleaf. Recommendations to improve the effectiveness of NHS smoking cessation services are clustered under three headings:

- Reducing variation in outcomes and improving consistency between services
- Increasing reach and success, particularly with priority groups
- Improving processes within services and training for staff

Bringing NHS services together under one national brand would establish a strong unifying identity and a recognisable national brand. A clear national process for referral could be created and developed including an e-referral system. National standards and protocols need to be developed and implemented by local services to address variation. Subsequent recommendations address many of the consistency issues which should help to reduce variation between local services, particularly with regard to prescribing of pharmacotherapies, behavioural support, improving CO validation and monitoring, and improving referral systems.

A further set of recommendations consider the need for services to improve reach with priority groups who have significantly higher rates of smoking. These centre around the need to design services flexibly, reflecting the needs of the service user, rather than expecting them to ‘fit in’ with a standard offering. This is particularly important when considering the recent downturn in client numbers which are anecdotally attributed to the rapid increase in the use of electronic cigarettes. Recent data from England suggests that many smokers use an e-cigarette to cut down or quit smoking and that the success rates when used as a quitting aid are higher than with willpower alone or with NRT bought over the counter. However, these outcomes are still much poorer than those achieved by accessing smoking cessation services. E-cigarette users should be encouraged to use specialist cessation services, even if continuing with e-cigarettes, to maximise their chances of achieving complete abstinence from tobacco use. In addition, greater emphasis should be placed on the distinctive nature of behavioural support within NHS smoking cessation services, the importance of which is often underplayed. There are
opportunities to make use of the behavioural skills needed to motivate a smoker to make a quit attempt and to change their behaviour by listening to their needs and designing a suitable programme for them to succeed.

However, it is likely that the reduction in numbers presenting at smoking cessation services may impact on NHS boards’ performance against the 2014/15 HEAT target. Service design and adaptation will be crucial to recruiting smokers into services. Attention also needs to be paid to retaining service users once recruited, maintaining engagement and proactive follow-up to try and prevent relapse.

This theme continues with improving processes within smoking cessation services as services do need to address poor follow-up and make better use of CO validation of quits as a means of monitoring and recording smokers’ status on a regular basis.

With regard to training, it is clear that an ongoing programme of training for specialist smoking cessation staff is urgently required. The new training programme should ideally use a blended approach, making use of e-learning to develop knowledge, supported by skills development and practical experience. The Scottish Government should consider options, develop a new specialist training specification and tender for this service as soon as possible.

A summary of the key recommendations contained within this report is given overleaf. These identify suggested actions required to improve consistency and consequently improve the service user experience.
### Summary of key recommendations

#### Reducing variation in quit outcomes and consistency between NHS Boards

1. A single recognisable national brand should be developed for smoking cessation in Scotland. This would create a strong unifying identity for smoking cessation services and also provide a simpler interface for self-referral with a national webpage, helpline and email contact, etc. It may also be possible to include wider smoke-free NHS strategy actions under this all-encompassing national brand.

2. National branding could also provide a more effective way of maintaining high visibility of NHS smoking cessation services through regular social marketing campaigns, which impact directly on the number of calls and referrals into services.

3. National prescribing protocols should be developed to improve access to current evidence-based pharmacotherapies, in particular varenicline and combination NRT.

4. National prescribing protocols should also be developed to ensure that a range of NRT products, including combination NRT (using more than one product concurrently) is available as an option for prescribing to all service users.

5. The research indicated that there was evidence of variable processes and timescales for clients to receive pharmacotherapies once in touch with services. National prescribing protocols need to ensure these are improved to expedite and streamline the service user experience.

6. National prescribing protocols need to ensure that NHS Boards improve access to varenicline, including provision through pharmacies and allowing smokers to use it as a first-line option.

7. Referral to specialist support services needs to be improved to maximise uptake of behavioural support and reduce prescribing of pharmacotherapy without support.

8. NHS Boards need to analyse their local prescribing data to identify usage, inform local planning and identify any gaps in provision.

9. Group support should be offered and encouraged over 1–1 or other types of support, whenever possible.

10. Links between different forms of support, such as pharmacy and specialist services should be improved together with better use and recording of ‘shared care’ on the national smoking cessation database, so that this can be monitored and its effectiveness evaluated.

11. Use of routine CO monitoring and recording must be improved. Scottish Government should re-emphasise the importance of regular validation, recording and monitoring of CO status to both specialist and pharmacy services.

12. Regular CO monitoring should also be used to provide feedback to service users as affirming their quit attempt and maintaining their motivation.

13. Formal feedback mechanisms should be developed to ensure client feedback is obtained and built into ongoing practice. This should also include the views of those who drop out of services prematurely and smokers who contact...
services but do not subsequently attend (DNAs).

14. Referrals from primary care to specialist support services should be improved.

15. A range of actions are needed to support smoke-free in acute settings. These include developing care pathways, better communication with patients, staff training, active support for smoke-free from senior NHS managers and the availability of specialist support in acute settings.

16. Generally, there is a need for a national campaign to better communicate the rationale for smoke-free grounds to the general public, all patients, visitors and NHS staff alike.

### Increasing reach and success, particularly with priority groups

17. Specialist smoking cessation service support should be focused on increasing the number of people quitting in priority groups (e.g. pregnant women, young people, people with mental health problems, prisoners and those living in disadvantaged areas where as many as 4 in 10 adults can be smokers).

18. Consideration will need to be given to ensure that the services understand the specific needs of their target audience and that the intervention offered is tailored to engage potential users. This may require some service redesign and consideration of innovative approaches with evidence of efficacy, such as the use of incentives. Proactive engagement with clients is likely to be required to ensure that service users can be supported and reengaged if they relapse.

19. Regular CO monitoring and recording should be a core part of service delivery as it is particularly useful as a motivational tool for clients.

20. Services will need to develop a community development approach by working and engaging closely with local communities and in partnership with the third sector in order to reach and support clients effectively.

21. Services need to consider and make use of new approaches such as cutting down to quit for smokers who find it difficult to stop abruptly. This allows the service to provide behavioural support to smokers over an agreed number of weeks with a view to setting a quit date and achieving abstinence from smoking.

22. Services should not refuse access to behavioural support for clients who are using electronic cigarettes.

23. The dynamic nature of smoking in young people differs from adult smoking patterns and is frequently linked with the use of other substances such as alcohol and cannabis. Young people do not tend to consider lifestyle behaviours in isolation and there a more holistic approach to risk-taking behaviours is required.

24. It is important that investment in prevention efforts does not detract from ongoing support and resource for smoking cessation services. A twin-track approach is required as one of the key determinants of a young person starting to smoke is whether their parents and others around them smoke.

25. There is a need to continue the drive for smoke-free settings set out in the strategy. The advisory group felt that there was potential to link activities on smoke-free NHS grounds with national branding for smoking cessation services [see also Recommendation 1].

26. Progress towards the outcomes of the McQIC programme should be regularly reviewed and monitored.
| 27. | Referrals received for pregnant women should be prioritised with a continued emphasis on the value of quitting at any stage of pregnancy and the importance of a smoke-free home. |
| 28. | NHS Health Scotland should update its existing resource aimed at pregnant women who smoke. |

**Improving processes within smoking cessation services and training**

| 29. | There is a need to improve follow-up data in Scotland. The 2014–15 HEAT target will require NHS Boards to improve follow up at 12 weeks and Boards should consider piloting a range of processes such as email and text messaging to improve follow up and enable reengagement. |
| 30. | Scottish Government should prioritise the implementation of national 12-month follow-up to improve the quality of national long-term follow-up statistics. |
| 31. | All clients making a quit attempt through pharmacy and non-pharmacy services should be seen face to face at 4 weeks and offered CO monitoring within the 4–6 week window of validation, consistent with the Russell standard. |

**Training**

| 32. | It is recommended that NHS Boards should investigate and ensure that all specialist smoking cessation advisers have received in-depth high-quality training in line with the national smoking cessation guidelines. |
| 33. | It is recommended that NHS Boards should ensure that specialist smoking cessation advisers have regular opportunities to access refresher and update training to ensure continued personal and professional development and competency. |
| 34. | Training opportunities for pharmacists, particularly in advance of the varenicline PGD, should be improved and also provide training opportunities, online or face to face for pharmacy technicians/counter staff. Pharmacy service providers should attend suitable revision/update training sessions to ensure continued personal and professional development and competency. |
| 35. | The Scottish National Training Standards should be reviewed and updated. |
| 36. | The Scottish Government should consider options, develop a new specialist training specification and tender for this as soon as possible. |
| 37. | Training for specialists needs to be more practical in the future, both in terms of length and regularity of training offered and for participants to learn from those with practical service experience. Consideration also needs to be given to the access needs of advisers in more remote and rural locations. It is recommended that a blended approach is used for training comprising an online platform supported by face-to-face skills development. |
| 38. | Training must also reflect the needs of local smoking cessation services to avoid the unnecessary duplication and expense of local areas developing separate training. |
| 39. | An alternative or additional option for staff development may be to consider a vocational qualification over a longer period of time; e.g. SVQ qualification, which could provide transferrable career development. |
| 40. | Future planning should include an appraisal of possible suitable training provision options within and outside Scotland. |
Appendix I

How can smoking cessation services increase successful quit attempts in Scotland?
ISD Scotland, Universities of Stirling and Bath (2014), funded by Scottish School of Public Health.

The Scottish School of Public Health provided funding to ISD Scotland, in collaboration with researchers from the Universities of Stirling and Bath, to conduct secondary analysis of routine monitoring data collected by NHS Smoking Cessation Services (SCS) in Scotland. This work took place between June 2012 and June 2013, with the bulk of the analysis conducted by Dr Jan Kerssens from ISD. This summary outlines key findings from this study, which focused on data collected from clients who accessed the services in 2010 and 2011. In this period 192,194 individuals set a quit date with their local SCS, which equates to 18% of Scotland’s smokers.

Service provided
The type of behavioural support and pharmacotherapy given to clients depends upon what the provider (the local Community Health Partnership (CHP) and Health Board) offers in the local area, as well as client choice. During the study period, over two thirds of clients (68%) received support to stop smoking in a pharmacy as part of the National Pharmacy Smoking Cessation Scheme and the remainder were seen by specialist smoking cessation advisers and GP practice staff. 78% clients received behavioural support on a one-to-one basis with an adviser and 15% joined groups (the remaining 7% received telephone support, couple or family support or a mixture). Clients living in more rural Health Board areas, such as the Highlands, were markedly less likely to receive treatment through the pharmacy scheme or receive group support, probably due to lower population density. The most common pharmacotherapy was a single NRT product (57%), followed by multiple NRT products (25%) and varenicline (9%).

Cessation
Clients set a quit date when they decide they are ready to stop smoking. Advisers follow up clients four weeks after this date to see whether they are abstinent. 38% clients reported that they had managed to quit. Older clients and more affluent clients were most likely to stop smoking. Clients who smoked fewer cigarettes a day and men were also slightly more likely to be successful in their quit attempt.

The type of treatment clients received also influences outcomes:

- Quit attempts in non-pharmacy settings were more successful (52%) than in pharmacy settings (32%)
- Clients receiving one-to-one support were least successful (35%) (50–60% clients receiving group support quit – depending on the type of group)
- Clients receiving varenicline were more successful (65%) than clients receiving single NRT (35%) or multiple product NRT (39%).
The analysis also found that outcomes varied between Community Health Partnerships:

- Overall, CHPs in rural areas had higher quit rates.
- CHPs with a lower volume of clients had higher quit rates.

**Service performance**

However, the outcomes described above involve fairly straightforward (or ‘crude’) analysis of routine data and don’t account for the complex relationship between client and service characteristics. As a result, multilevel multiple logistic regression models adjusting for client and treatment mix were used to produce adjusted percentages of successful quit attempts (quit rates) for each Community Health Partnership. These were then compared with the service uptake rates. By doing this, the analysis tried to capture the ‘impact’ of services:

- Services where a client had the best chances of **stopping smoking** were: North, South and East Ayrshire, Kirkcaldy & Levenmouth, Clackmannanshire, Aberdeen City, Aberdeenshire, Moray, Mid and North Highland

- Services who **reached** more than a fifth of their local smoking populations were: East and West Dunbartonshire; North, East, South West and South East Glasgow; Renfrewshire, and North and South Lanarkshire

- Services with the highest **impact** (likely to create the most non-smokers per 100 local smokers) were: North Ayrshire, Aberdeenshire, East and West Dunbartonshire, East Glasgow, North and South Lanarkshire

A comparison of crude and adjusted quit rates led to the following recommendations for improving services:

- Clients who took varenicline were twice as likely to quit as those who took single NRT (Odds Ratio 2.10(2.02–2.19)). All Community Health Partnerships could promote a greater use of varenicline, however. We know that in England, by way of comparison, 26% of clients took varenicline compared with just 9% in Scotland. Scottish Borders SCS, East Lothian SCS, Glenrothes & North East Fife SCS, Kirkcaldy & Levenmouth SCS and Stirling SCS might particularly profit from an increase in varenicline.

- Taking multiple NRT compared to single NRT slightly improved the chances of quitting (Odds Ratio 1.13(1.10–1.15)). Services in NHS Grampian, NHS Greater Glasgow and Clyde and North Lanarkshire SCS, Mid Highland SCS, North Highland SCS, Angus SCS and Dundee SCS might obtain higher quit rates if they increased the use of multiple NRT products.

- Clients who joined groups were nearly 30% more likely to quit than clients who received one-to-one support (Odds Ratios: open groups (1.27(1.22–1.33) closed groups 1.29 (1.23–1.36)). Quit rates in Glenrothes & North East Fife SCS, Kirkcaldy & Levenmouth SCS and Stirling SCS might improve with a greater use of either closed or open group support.
More research is needed to determine all the possible reasons for the variation in quit rates, as the analysis could not account for all possible explanations. This is shown in particular by the case of Perth and Kinross SCS, who despite having above average levels of non-pharmacy support, group support and multiple NRT and varenicline, had the lowest quit rate.

**Conclusion**

Smoking cessation provision varies widely between CHPs in Scotland. Ideally, services need to aim for a high quit rate and a wide reach in order to make a greater contribution to reducing smoking in their local communities. Group support (both open and closed groups) and greater use of varenicline are obvious areas for further development.

Appendix 1 – Percentage of quit attempts for intervention setting, intervention type and medication; quit rates, reach and impact of Scotland’s Smoking Cessation Services (2010–2011)
<table>
<thead>
<tr>
<th>Intervention Setting</th>
<th>Medication</th>
<th>Intervention Type</th>
<th>Crude quit rate</th>
<th>Smokers reached</th>
<th>Impact: Quitters per 100 smokers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pharmacy</td>
<td>Multiple NRT</td>
<td>Varenicline</td>
<td>Group support</td>
<td></td>
</tr>
<tr>
<td>East Ayrshire SCS</td>
<td>83%</td>
<td>57%</td>
<td>6%</td>
<td>11%</td>
<td>51%</td>
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<tr>
<td>North Ayrshire SCS</td>
<td>86%</td>
<td>58%</td>
<td>10%</td>
<td>9%</td>
<td>51%</td>
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<tr>
<td>South Ayrshire SCS</td>
<td>89%</td>
<td>47%</td>
<td>12%</td>
<td>6%</td>
<td>47%</td>
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<tr>
<td>Scottish Borders SCS</td>
<td>59%</td>
<td>46%</td>
<td>9%</td>
<td>6%</td>
<td>40%</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway SCS</td>
<td>34%</td>
<td>16%</td>
<td>22%</td>
<td>4%</td>
<td>29%</td>
</tr>
<tr>
<td>Dunfermline &amp; West Fife SCS</td>
<td>39%</td>
<td>41%</td>
<td>18%</td>
<td>8%</td>
<td>34%</td>
</tr>
<tr>
<td>Glenrothes &amp; North East Fife SCS</td>
<td>63%</td>
<td>40%</td>
<td>7%</td>
<td>4%</td>
<td>35%</td>
</tr>
<tr>
<td>Kirkcaldy &amp; Levenmouth SCS</td>
<td>62%</td>
<td>42%</td>
<td>9%</td>
<td>2%</td>
<td>38%</td>
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<tr>
<td>Gallowayshire SCS</td>
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<td>51%</td>
<td>12%</td>
<td>39%</td>
<td>38%</td>
</tr>
<tr>
<td>Falkirk SCS</td>
<td>58%</td>
<td>34%</td>
<td>16%</td>
<td>25%</td>
<td>40%</td>
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<tr>
<td>Stirling SCS</td>
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<td>3%</td>
<td>38%</td>
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<tr>
<td>Aberdeenshire SCS</td>
<td>88%</td>
<td>33%</td>
<td>8%</td>
<td>10%</td>
<td>47%</td>
</tr>
<tr>
<td>Aberdeenshire SCS</td>
<td>83%</td>
<td>27%</td>
<td>13%</td>
<td>15%</td>
<td>49%</td>
</tr>
<tr>
<td>Moray SCS</td>
<td>88%</td>
<td>34%</td>
<td>7%</td>
<td>10%</td>
<td>44%</td>
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<tr>
<td>East Dunbartonshire SCS</td>
<td>73%</td>
<td>13%</td>
<td>14%</td>
<td>10%</td>
<td>36%</td>
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<td>East Renfrewshire SCS</td>
<td>74%</td>
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<td>12%</td>
<td>22%</td>
<td>36%</td>
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<tr>
<td>North Glasgow SCS</td>
<td>86%</td>
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<td>5%</td>
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<td>7%</td>
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<tr>
<td>West Glasgow SCS</td>
<td>91%</td>
<td>20%</td>
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<td>89%</td>
<td>17%</td>
<td>7%</td>
<td>5%</td>
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<td>South East Glasgow SCS</td>
<td>82%</td>
<td>19%</td>
<td>9%</td>
<td>12%</td>
<td>35%</td>
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<tr>
<td>Inverclyde SCS</td>
<td>82%</td>
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<td>12%</td>
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<td>Renfrewshire SCS</td>
<td>82%</td>
<td>16%</td>
<td>10%</td>
<td>11%</td>
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</tr>
<tr>
<td>West Dunbartonshire SCS</td>
<td>86%</td>
<td>20%</td>
<td>9%</td>
<td>9%</td>
<td>35%</td>
</tr>
<tr>
<td>Argyll &amp; Bute SCS</td>
<td>15%</td>
<td>16%</td>
<td>14%</td>
<td>1%</td>
<td>33%</td>
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<tr>
<td>Mid Highland SCS</td>
<td>19%</td>
<td>28%</td>
<td>25%</td>
<td>6%</td>
<td>55%</td>
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<tr>
<td>North Highland SCS</td>
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<td>31%</td>
<td>7%</td>
<td>1%</td>
<td>42%</td>
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<tr>
<td>South East Highland SCS</td>
<td>8%</td>
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<td>9%</td>
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<tr>
<td>East Lothian SCS</td>
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<td>Orkney SCS</td>
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<tr>
<td>Perth &amp; Kinross SCS</td>
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<tr>
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<tr>
<td>Median</td>
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<tr>
<td>Maximum</td>
<td>91%</td>
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<td>26%</td>
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<td>55%</td>
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<tr>
<td>Minimum</td>
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<td>12%</td>
<td>4%</td>
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<td>28%</td>
</tr>
<tr>
<td>Total (Scotland)</td>
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<td>25%</td>
<td>9%</td>
<td>15%</td>
<td>38%</td>
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</tbody>
</table>

Coloured cells indicate percentages above the Scottish average, and highlights indicate quit rates above 45%, above 20% smoking population reached and 9 or more non smokers created per 100 smokers.

**Smokers reached** based on mid-2010 populations and smoking rate from Scottish Household Survey 2009/10
1. Pharmacy shown only. Non-pharmacy figure (%) equates to: 100 – pharmacy figure (%)
2. Multiple NRT and Varenicline shown only. 'Other/Alternative' figure (%) equates to: 100 – [Multiple NRT (%) + Varenicline figure (%)]
3. Group Support shown only. Non-group support figure (%) equates to: 100 – group support figure (%)
### Appendix II

## Harm-reduction approaches

<table>
<thead>
<tr>
<th>Approach</th>
<th>Details</th>
<th>Advocate</th>
</tr>
</thead>
</table>
| **Smoking cessation** | Smoking cessation:  
• is the best way to improve the health of a smoker and of those around them  
• offers the best chance of smoking cessation long term [c.f. NICE PHG10/*Guide to smoking cessation in Scotland*]  
• is least costly  

Group/1:1 behavioural support from SCSs plus pharmacotherapy is the best way of achieving this and long term. | Gold standard.  
Boards/SCSs should continue to provide this through SCSs – with behavioural support and pharmacotherapy. |
| **Cutting down to quit** | **Health:** Large health benefits post-cessation.  
**Effectiveness:** CDTQ effective with NRT (NRT is effective for short-term reduction) or behavioural support. Similar success rates to smoking cessation.  
**Safety:** Likely to be safe if current NRT use and cigarette use is of short duration (mixed/gaps in evidence re combined use of NRT and cigarettes). | Boards/SCSs should provide this through SCSs, with behavioural support and NRT, and start working on developing referral and treatment pathways. |
| **E-cigarette use**   | Limited evidence to date on quality, safety and efficacy although emerging evidence on effectiveness in 'real world' settings for smoking cessation. Evidence that they are less harmful than smoking although questions remain on longer-term use. Not currently regulated, and limited consistency between brands in terms of contents/ingredients or mechanisms of action, with an ever-increasing range of products. If/once products become regulated, this should ensure quality standards for the regulated products.  

Boards/SCSs have a role to play in helping smokers who use e-cigarettes to achieve complete abstinence from tobacco. Ideally e-cigarette users should be persuaded to switch to licensed nicotine containing products and use these alongside the behavioural support provided by services. However, if a client chooses to continue using an e-cigarette, support should not be denied. Smokers who are keen to stop using e-cigarettes altogether should be supported to do so. If an e-cigarette product becomes licensed as a smoking cessation medicine, then NHS Boards will need to consider whether to make it available on prescription.  

See [www.healthscotland.com/documents/4661.aspx](http://www.healthscotland.com/documents/4661.aspx) (harm-reduction addendum) for specific | Boards/SCSs should avail of opportunities to engage e-cigarette users and provide them with support in order to assist them to stop using all forms of tobacco. However, as an unlicensed product, e-cigarettes cannot be recommended and clients should be encouraged to use approved pharmacotherapies alongside behavioural support. |
| Smoking cessation + long-term NRT use to remain quit | **Health**: If effective, could potentially bring large health benefits.  
**Effectiveness**: Studies are limited and inconclusive. There are gaps in evidence re long-term use of NRT.  
**Safety**: Long-term use of NRT is safe for < 5 years but evidence beyond is lacking; lifetime use is likely to be considerably safer than smoking (expert opinion). | Boards/SCSs should consider providing NRT for this (for a reasonable duration), in particular for clients who have quit through SCSs. |
|--------------------------------------------------|------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| Temporary abstinence | **Health**: Unlikely to have lasting health benefits; however, better to use licensed NCPs (i.e. NRT) than to smoke. Potential health benefits to others through SHS reduction.  
**Effectiveness**: NRT is effective even without behavioural support; mixed/gaps in evidence re harm-reduction methods (e.g. re use of behavioural support when no intention to quit).  
**Safety**: Mixed/gaps in the evidence re combined use of NRT and cigarettes (e.g. mild/moderate adverse events when used for reduction), long-term use of NRT.  
**Other**: May provide opportunities of future engagement for smoking cessation. | Boards/SCSs should: provide NRT for this (for a reasonable duration) in some involuntary abstinence situations (e.g. inpatient/hospital admission, prisons); consider providing it in other such situations; signpost to pharmacies for advice and purchase of NRT in other cases. |
| Cutting down / smoking reduction per se | **Health**: No clear evidence re the health benefits of cutting down without cessation.  
**Effectiveness**: Reductions tend to be short term only rather than sustained. No evidence for behavioural support. NRT improves likelihood of reduction but reductions are not matched by proportionate biochemical reductions.  
**Safety**: Mixed/gaps in evidence re combined use of NRT and cigarettes, and mild/moderate adverse effects when NRT used for reduction.  
**Other**: Preliminary evidence for eventual quitting among reducers—even if not planning to quit, particularly if NCPs are used. | Boards/SCSs should: signpost to pharmacies for advice and purchase of NRT for this; consider providing NRT for this in some circumstances (for a time-limited duration); provide support and NRT if/once quit date ready to be set and therefore CDTQ or smoking cessation approach to be undertaken. |
# Appendix III

**Membership of the Advisory Group**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professor Linda Bauld (Chair)</td>
<td>Professor of Health Policy, University of Stirling and UK Centre for Tobacco and Alcohol Studies</td>
</tr>
<tr>
<td>Professor Amanda Amos</td>
<td>Professor of Health Promotion University of Edinburgh</td>
</tr>
<tr>
<td>Kate Barlow</td>
<td>Senior Health Improvement Officer (Tobacco), NHS Health Scotland (from December 2013)</td>
</tr>
<tr>
<td>Andy Bruce</td>
<td>Team Leader: Tobacco, Alcohol &amp; Diet, Public Health Division, Scottish Government (until August 2013)</td>
</tr>
<tr>
<td>Marjory Burns (Minutes only)</td>
<td>Director, British Heart Foundation Scotland</td>
</tr>
<tr>
<td>Dr James Cant</td>
<td>Head of British Lung Foundation in Scotland and Northern Ireland</td>
</tr>
<tr>
<td>Sheila Duffy</td>
<td>Chief Executive, ASH Scotland (from September 2013)</td>
</tr>
<tr>
<td>Fiona Dunlop</td>
<td>Health Improvement Lead (Tobacco), NHS Greater Glasgow &amp; Clyde</td>
</tr>
<tr>
<td>Celia Gardiner</td>
<td>Health Improvement Programme Manager (Tobacco), NHS Health Scotland</td>
</tr>
<tr>
<td>Dr Dermot Gorman</td>
<td>Consultant in Public Health Medicine, NHS Lothian</td>
</tr>
<tr>
<td>Trish Grierson</td>
<td>Tobacco Control Lead/Service Manager, NHS Dumfries &amp; Galloway</td>
</tr>
<tr>
<td>Professor Sally Haw</td>
<td>Professor of Public and Population Health, University of Stirling</td>
</tr>
<tr>
<td>Clare Hyatt</td>
<td>Project Administrator, NHS Health Scotland</td>
</tr>
<tr>
<td>Richard Lawder</td>
<td>Principal Information Analyst, Health Improvement (Smoking Cessation), Information Services Division (ISD), NHS National Services Scotland</td>
</tr>
<tr>
<td>Siobhan Mackay</td>
<td>Tobacco Policy, Public Health Division, Scottish Government (from September 2013)</td>
</tr>
<tr>
<td>Fiona Moore</td>
<td>Public Health Adviser, NHS Health Scotland</td>
</tr>
<tr>
<td>Jane Oliver</td>
<td>Programme Officer (Tobacco), NHS Health Scotland (to September 2013)</td>
</tr>
<tr>
<td>Brian Pringle</td>
<td>Director of Projects &amp; Services, ASH Scotland (to September 2013)</td>
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<tr>
<td>Andrew Radley</td>
<td>Consultant in Public Health Pharmacy, NHS Tayside</td>
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<tr>
<td>Rebecca Sludden</td>
<td>Research Officer, NHS Health Scotland</td>
</tr>
<tr>
<td>Cathy Steer</td>
<td>Head of Health Improvement, NHS Highland</td>
</tr>
<tr>
<td>Jackie Willis</td>
<td>Team Head, Healthy Behaviours Team, NHS Health Scotland</td>
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</table>
References


2. NICE. Public Health Guidance 14 – *Preventing the uptake of smoking by children and young people: mass-media and point-of-sales measures to prevent the uptake of smoking by children and young people.* London: NICE; 2008. [www.nice.org.uk/PH14](http://www.nice.org.uk/PH14)


4. ISD Scotland, Universities of Stirling and Bath. *How can smoking cessation services increase successful quit attempts in Scotland?* Glasgow: Scottish School of Public Health; 2014.


