Smoking cessation support in secondary care in Scotland
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There is a growing evidence base regarding the efficacy of smoking cessation interventions in secondary care which suggests that interventions which begin during a hospital stay and include post-discharge follow-up are effective in helping people to quit. Less is known about what precise form or combination of services is likely to be most effective, and how these should be implemented. This study aimed to map the extent and nature of cessation support in secondary care in Scotland, to highlight possible gaps and new learning, to provide examples of promising practice, and to compare current practice with existing guidance.

A mixed methods approach was employed spread over three stages. Stage 1 involved telephone enquiries with the main tobacco lead(s) in each health board area (n = 16). In Stage 2, self-completion questionnaires were sent to all hospital service leads identified from Stage 1 (n = 23). Stage 3 involved site visits to six services in Scotland and England to obtain more detailed insights into aspects of service delivery and examples of promising practice (n = 27). The findings from each stage were used to inform the sample, question areas and analysis of the stages that followed.

The study identified 33 hospitals, mainly acute ones, in 12 of the Scottish health board areas that were providing or developing dedicated smoking cessation support. Lower levels of activity were observed in hospitals in smaller rural health boards, which were attributed to resource constraints. Most services are delivered by specialist smoking cessation advisers who support and take referrals from frontline nursing and medical staff. In two hospitals the service is led by respiratory nurse specialists with additional training in smoking cessation, who have a proportion of their time allocated to cessation work.

The majority of hospital services refer patients who wish for continued support on discharge to specialist community-based services. In some smaller rural health boards the same adviser continues to see the patient after discharge. In one area where the specialist community service is not equipped to take referrals, the hospital service offers continued support by telephone. Attrition rates between discharge and being picked up by community services are described as high.

Most hospitals that provide dedicated support are covered by one part-time or full-time specialist adviser, although in some instances support is provided remotely either from another specialist or from the community. Most services report staff resources to be stretched, in some instances severely, with many operating without any dedicated administrative support. This often means that the goal of offering a hospital-wide cessation service is compromised.

Taken together, these findings indicate that a significant proportion of patients in Scottish hospitals have no access to on-site specialist cessation support, and where it is available it tends to be focused on specific departments, typically inpatient acute services, and respiratory and cardiology departments.

The current guidelines suggest that NHS patient populations, including inpatients, should be offered structured behavioural support and medication while in hospital, and continued support by smoking cessation services on discharge. Findings indicate that although some hospitals aspire to provide all patients with access to specialist behavioural and pharmacological support, in practice hospital support is often limited to certain areas. Many other hospitals would appear not to have any form of specialised cessation support available to patients.

Recent guidance updates emphasise that hospital clinicians and nurses should be encouraged to access accredited training on brief advice, to refer people who smoke to intensive smoking cessation services and, if appropriate, to offer patients a
Findings indicate that in hospitals where dedicated smoking cessation advice is available, clinical and nursing staff have access to training in brief advice, but in many instances are unable to take advantage of this training due to staff pressures and the low priority attached to smoking cessation. Low uptake of brief advice training has a limiting effect on the numbers of patients who are referred to smoking cessation services in the community and to specialist hospital cessation services, where these exist. The majority of hospitals with dedicated smoking cessation support also provide patients who are attempting to quit with a supply of or prescription for pharmacotherapy on discharge. Provision of pharmacotherapies in hospitals without dedicated cessation support is less clear.

Findings indicate that the support of a dedicated specialist working from within or in close proximity to the hospital site is a prerequisite for any successful service. The effectiveness of services that rely upon frontline staff to provide brief advice and referral to the community is extremely limited insofar as they generate only small numbers of referrals. Two main models of provision of dedicated support were identified, namely a hospital-led service model with ongoing cessation support provided from the hospital service post discharge, and an integrated service model with specialist cessation services in the hospital and community working together to an agreed joint service protocol. Currently most specialist hospital services in Scotland are based on variants of the latter model.

Findings reveal 27 learning points for guiding the development and delivery of cessation support in secondary care, which could form a basis for agreeing a set of quality standards. These are detailed in the Conclusions section and relate to the areas of service development, management and staffing, referral within the hospital, provision of pharmacotherapies, referral to the community, training, and monitoring.

Finally, the findings highlight the need for further research to examine the relationship between different models of smoking cessation support in secondary care and cessation outcomes, and to compare existing data on cessation outcomes for hospital referrals with those for referrals to specialist community services from other settings.
1. Introduction

Smoking remains the leading cause of preventable ill health and death in Scotland, as it is in all developed countries. In the past 10 years, since the publication of the 1998 White Paper, Smoking Kills, huge progress has been made in developing and implementing a comprehensive tobacco control strategy in Scotland and across the rest of the UK. An important part of this strategy is the provision of services to support smokers in quitting, and the UK has led the way in the development of comprehensive smoking cessation services, free at the point of use, within the NHS (McNeill et al., 2005). In Scotland, these services now exist in every health board. Supported by considerable investment from the Scottish Executive, they deliver behavioural support plus access to appropriate pharmacotherapies in a range of settings.

The Scottish smoking cessation guidelines outline recommendations for the provision of support to help smokers, including hospital inpatients, to quit. Recommendation 3 (NHS Health Scotland/ASH Scotland, 2004: 22) states that:

Specific populations of NHS patients, such as hospital inpatients and pregnant smokers, should, as far as possible, be offered smoking cessation treatment appropriate to their circumstances at locations and schedules to suit them … Hospital inpatients who smoke should be routinely offered structured behavioural support and medication during their stay and continued support by the SCS on discharge.

The guidelines also make a number of recommendations about the provision of brief advice from a range of health professionals, pharmacotherapy and wider organisational issues including, among others, the staffing and financing of smoking cessation services, although these are not specific to secondary care.

In 2007 these guidelines were updated through the publication of a supplement outlining recent relevant developments (since 2004) (NHS Health Scotland/ASH Scotland, 2007). This update outlined the implications for Scotland of National Institute for Health and Clinical Excellence (NICE) guidance in England on brief interventions and referral for smoking cessation, emphasising, among other points, that a range of health professionals, including hospital clinicians and nurses, should be encouraged to access accredited training in brief advice, refer people who smoke to intensive smoking cessation services and, if appropriate, offer patients a prescription for pharmacotherapy (NHS Health Scotland/ASH Scotland, 2007). The guidance also outlined the extension to the licensing of nicotine replacement therapy (NRT) introduced in 2005 by the Committee on Safety of Medicines to a number of patient groups, including those with heart disease, kidney or liver problems and diabetes, for whom NRT was previously not recommended.

Finally, basic information on other pharmacotherapies (bupropion and varenicline) was included, as well as a description of a number of other recent developments.

In addition to smoking cessation guidelines in Scotland, guidance on smoking cessation in secondary care has been published by the British Thoracic Society (2003). A recent Cochrane review has assessed the evidence for interventions for smoking cessation in hospitalised patients (Rigotti et al., 2007). In addition, NICE included secondary care in the development of its 2008 guidance on smoking cessation support.

There is therefore growing interest and growing evidence relating to the efficacy of smoking cessation interventions initiated in secondary care. Overall, the available evidence suggests that following an admission to hospital, or other healthcare contacts (e.g. through outpatients, chronic disease management and rehabilitation services), individuals may be more open to accepting help to enable them to quit smoking (Bell et al., 2007; Rigotti et al., 2007). This is
particularly likely if they are suffering from a smoking-related disease. A significant body of evidence now exists (33 trials included in the recent Cochrane review) which suggests that smoking cessation programmes that begin during a hospital stay and include follow-up for at least 1 month after discharge are effective in helping people to stop (Rigotti et al., 2007). The Cochrane review suggests that these programmes can be effective for all groups of patients, including those with cardiovascular disease. The review also suggests that the evidence of benefit from NRT or bupropion with hospital inpatients is equivalent to that with patients in other settings.

It is clear, therefore, that smoking cessation interventions that are initiated in hospital can be effective, if they include adequate post-discharge follow-up. What is much less certain is what precise form or combination of services is likely to be most effective (i.e. who should deliver it, when and for how long), and how precisely knowledge about effective interventions should be implemented in practice. Despite these limitations, a number of health boards in Scotland, and in other parts of the UK, have developed smoking cessation support services for hospital patients, be they inpatients or smokers attending outpatient services.

This report outlines findings from a national mapping exercise of smoking cessation support in secondary care in Scotland. The research aimed to map the current extent and nature of cessation support in secondary care, highlighting gaps and also providing examples of promising practice. In doing so, the study recognised that support for stopping smoking in secondary care represents part of a continuum, rather than a single intervention. It may vary from brief advice and information through to intensive support and the provision of NRT or other pharmacotherapies in hospital. It may also involve several settings both in hospital and in the community, and may be enhanced by telephone support.

The specific objectives of the study were as follows:

- to map the current provision of smoking cessation support for patients accessing hospital-based treatment
- to describe the referral protocol and ‘pathway’ for each identified local primary-care-based smoking cessation service with secondary care
- to describe the referral protocol and ‘pathway’ for each identified hospital-based smoking cessation service within secondary care
- to determine the source of referrals
- to identify gaps in referrals from specialties, where possible
- to determine the uptake of smoking cessation services by inpatients, outpatients and pre-admission patients, depending on existing data
- to compare referral protocols and pathways identified
- to compare current practice with the Scottish guidelines
- to explore examples of best practice in Scotland and elsewhere
- to consider the findings in relation to the NICE guidance published in 2008.

Following the delay in publication of the NICE guidance on smoking cessation to February 2008, the Scottish commentary has been incorporated as an appendix (see Appendix 4).
2. Methods

In order to provide both broad-level evidence of the range of activities currently in progress in Scotland and more detailed information on delivery of individual services, a mix of methods was employed, incorporating face-to-face interviews, telephone enquiry, self-completion questionnaires, and collection and analysis of service documentation and monitoring data. The study was also divided into three data collection stages. Stage 1 involved telephone enquiries with the main tobacco lead(s) in each health board to identify specialist services operating in secondary care in their area. In Stage 2, self-completion questionnaires were sent to all hospital service leads identified from Stage 1 to assess aspects of service provision. Stage 3 involved site visits to a small cross-section of services to obtain more detailed insights into service development issues and different models of delivery (see Table 2.1).

Table 2.1: Summary of methods

<table>
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<tr>
<th>Research stage</th>
<th>Sample profile</th>
<th>Sample size</th>
<th>Methods</th>
</tr>
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<tr>
<td>Stage 1: Mapping services</td>
<td>Health board tobacco leads</td>
<td>n = 16</td>
<td>Telephone note taking and supplementary information by email</td>
</tr>
<tr>
<td>Stage 2: Assessing provision</td>
<td>Hospital service leads</td>
<td>n = 23 (20 completed returns)</td>
<td>Self-completion questionnaire and supplementary</td>
</tr>
<tr>
<td>Stage 3: Exploring delivery</td>
<td>Service leads, hospital and community advisers, hospital consultants and nursing staff, practice nurses, community pharmacists</td>
<td>n = 27 (across 6 services)</td>
<td>Hospital field visits. Audio-recorded one-to-one and paired interviews and mini-groups. Collection and analysis of service documentation and data</td>
</tr>
</tbody>
</table>

Resource and time constraints meant that it was not practicable to include service users or to consult with all of the relevant hospital departments across Scotland. The study adopted a cumulative approach, with each stage informing the sample, question areas and analysis of the stages that followed.

Stage 1: Mapping services.
Tobacco leads from all 14 health boards were invited to take part by letter in the first instance, and a time was arranged for interview by telephone and email. All participants were sent a written outline of the main areas of enquiry so that they could prepare in advance. As well as identifying hospital-based smoking cessation activity and contact details for service leads in their health board area, the interviews were also used to provide some preliminary insights into the nature of these activities. This information was used to inform the design and content of the Stage 2 self-completion questionnaire, and to provide contextual information to assist with the analysis of the Stage 2 data.

Stage 2: Assessing provision.
A semi-structured self-completion questionnaire was sent to all service leads providing and/or coordinating cessation services in secondary care identified from the Stage 1 interviews. The questionnaire combined both pre-coded and open-ended questions, and was divided into six main areas of enquiry, namely service development, patient support, provision of pharmacotherapies, links with community-based cessation services, training and awareness-raising activities, and procedures for monitoring patient smoking.
behaviour. It also included self-evaluation sections examining factors which helped and hindered service delivery and patient referral. In addition to completing the questionnaire, respondents were also invited to provide supplementary material. This included items such as unpublished evaluation reports and data, service protocols, training schedules, publicity material and hospital tobacco policies. Hard copies of the questionnaire were posted to all prospective respondents with a freepost return address, along with the option of completing an electronic version by email. Respondent confidentiality was guaranteed as part of the consent procedure. Respondents who did not return completed questionnaires within the initial deadline were followed up on two separate occasions by a combination of letter, email and telephone, and the questionnaire was reissued at each stage.

**Stage 3: Exploring delivery.** A total of six services (four in Scotland and two in England) were selected for more detailed study to examine aspects of promising practice. The Scottish case studies were identified using information gained from the Stage 1 and 2 enquiries, and applied a range of criteria designed to represent:

- a cross-section of service models and approaches
- services which covered a variety of hospital departments and which employed different methods of delivering support
- services which served both urban and rural communities.

The English case studies were selected as examples of well-developed secondary care services on the basis of information obtained from other researchers and practitioners working in smoking cessation services in England. Service characteristics examined in all six case studies included service history, current service provision, patient characteristics, referral methods (both within the hospital setting and to the community), outcome measures and monitoring procedures, recruitment and publicity, barriers and facilitators, and future plans. The interview content for the Scottish case studies was tailored to reflect the emerging findings from the Stage 1 and 2 enquiries. A single site visit was made to each service, and interviews with key informants were arranged in advance. In some instances visits were followed up with an additional telephone enquiry. A total of 27 respondents took part in this stage of the study and included the service leads, clinical leads and representatives from referral sources and agencies to whom patients were referred. As with Stage 2, the researcher also used the interview as an opportunity to collect relevant support materials and documentation. All Stage 3 interviews were recorded on audio file with the respondent’s consent and transcribed for thematic analysis.
3. Overview of service support

This section reports the findings from a combined analysis of Stage 1 interviews, Stage 2 self-completion questionnaires, and service documentation provided by the individual services. It is divided into 10 main areas: response rates (Section 3.1), level of provision (Section 3.2), targeting and coverage (Section 3.3), patient recruitment (Section 3.4), patient support (Section 3.5), pharmacological support (Section 3.6), referral to the community (Section 3.7), training (Section 3.8), monitoring (Section 3.9), and factors that inhibit and facilitate delivery (Section 3.10). In addition to the analysis of the Stage 1 and 2 data, the findings presented here were also informed by the Stage 3 Scottish case studies.

3.1 Response rates

In total, 13 of the 14 health board tobacco leads who took part in the Stage 1 enquiries reported secondary care smoking cessation services either in existence or actively being developed in their health board area. The one board area where no activity was reported was a small rural health board. Tobacco leads provided contact details for 23 individuals responsible for developing and delivering hospital cessation support, all of whom were subsequently sent questionnaires. In seven of the active health boards reported to be active, one service lead was identified, with two or more leads identified in the remaining six. The largest number of service leads identified in a single board area was four.

A total of 20 completed questionnaires were returned. In some health boards more than one return was received from advisers responsible for different elements of the same service. A service was defined as an individual or team with time dedicated to providing specialist behavioural support to patients who initiate a quit attempt while receiving treatment in secondary care. The three non-responders were in separate health board areas – two were in rural health boards and the third was in a larger urban health board. Responses indicated specialist smoking cessation activity in hospitals in most areas, with less activity in smaller rural health board areas.

3.2 Level of provision

A summary of provision by health board area is provided in Table 3.1. A total of 15 services were identified. These ranged from small services with a single adviser operating in relative isolation, normally covering a single hospital site, to larger services with a team of advisers covering multiple sites. A total of 28 hospitals were actively engaged in providing dedicated smoking cessation support to patients at the time of the study, and the majority of these were general hospitals with acute services. In five additional hospitals cessation support was at either the planning or early implementation stage, while in four others either completed questionnaires were not received or the adviser in post was on long-term sick leave.
Table 3.1: Provision by health board area

<table>
<thead>
<tr>
<th>Health board</th>
<th>Number of hospitals with specialist support (planned or under development)</th>
<th>Number of services</th>
<th>Number of advisers (full-time/part-time)</th>
<th>Number of advisers (full-time/part-time)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayrshire and Arran</td>
<td>5</td>
<td>1</td>
<td>2(0/2)</td>
<td>No</td>
</tr>
<tr>
<td>Borders</td>
<td>1</td>
<td>1</td>
<td>2(0/2)</td>
<td>Yes</td>
</tr>
<tr>
<td>Dumfries and Galloway</td>
<td>(2)</td>
<td>1</td>
<td>1(1/0)</td>
<td>Yes</td>
</tr>
<tr>
<td>Fife</td>
<td>2</td>
<td>1</td>
<td>0*</td>
<td>No</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>2</td>
<td>1</td>
<td>3(0/3)</td>
<td>Yes</td>
</tr>
<tr>
<td>Grampian</td>
<td>3</td>
<td>1</td>
<td>3(2/1)</td>
<td>0.3%</td>
</tr>
<tr>
<td>Greater Glasgow and Clyde</td>
<td>7</td>
<td>2</td>
<td>7(4/3)</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Highlands and Argyll</td>
<td>3</td>
<td>3</td>
<td>3(0/3)**</td>
<td>No</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>2(1)</td>
<td>1</td>
<td>2(2/0)</td>
<td>Yes</td>
</tr>
<tr>
<td>Lothian</td>
<td>2</td>
<td>1</td>
<td>1(1/0)</td>
<td>Yes</td>
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<tr>
<td>Orkney</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>NA</td>
</tr>
<tr>
<td>Shetland</td>
<td>1</td>
<td>1</td>
<td>1(1/0)**</td>
<td>No</td>
</tr>
<tr>
<td>Tayside</td>
<td>(2)</td>
<td>1</td>
<td>1(1/0)</td>
<td>Yes</td>
</tr>
<tr>
<td>Western Isles</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>NA</td>
</tr>
<tr>
<td>Total</td>
<td>28(5)</td>
<td>15</td>
<td>26(12/14)</td>
<td>--</td>
</tr>
</tbody>
</table>

*Specialist support provided by three respiratory nurse specialists with training in cessation support.

** Adviser works across a number of settings, including secondary care.
The intensity of support provided also varied between sites. In all but one site, service support is delivered by specialist smoking cessation advisers from health and non-health backgrounds, who support and take referrals from frontline nursing and medical staff and operate either from a permanent base within the hospital site, or from an external base that is either in the community or in another hospital. In the exceptional case the service is led by respiratory nurse specialists with additional training in smoking cessation who have a proportion of their time allocated to cessation work.

The 28 hospitals with specialist support were covered by 12 full-time cessation advisers and 14 part-time advisers. The majority of hospitals have the support of one adviser, although in practice this support is often shared between more than one hospital, and is sometimes provided remotely with advisers based off-site. Four advisers covering two rural health board areas also have their time split between providing support in the community and in secondary care.

While it is acknowledged that these data provide only rough estimates of coverage, they do indicate that staff-to-hospital ratios are broadly consistent across the country. However, it is noteworthy that it was frequently reported that staff resources were stretched and that services needed to be limited to fit with available capacity. This was most noticeable in two particular health board areas. In one area the full-time adviser in post is responsible for covering more than one hospital, and is sometimes provided remotely with advisers based off-site. Four advisers covering two rural health board areas also have their time split between providing support in the community and in secondary care.

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Taken together, these findings indicate that although dedicated support tends to be provided in larger hospitals, a significant proportion of patients in Scottish hospitals have no access to on-site specialist cessation support, and where this support does exist its delivery is often hampered by inadequate staff resources, with support restricted to certain departments.

### 3.3 Targeting and coverage

Most of the services identified aspire to provide a hospital-wide service with equal access for all patients although, in practice, resource constraints and variations in frontline staff's willingness to engage with cessation services mean that support is focused in particular departments and areas. Cessation support is most widely available in inpatient acute departments (or ‘on the wards’) and through respiratory services and rehabilitation services for coronary heart disease and, to a lesser extent, stroke. Staff working in respiratory and coronary care are reported to be more conscious of the links between smoking and the diseases that they treat, and receptive to receiving additional support. Most services were also able to identify other areas such as pre-operative assessment and mental health, where further development is required. Health priorities can also influence where resources are targeted, with respondents indicating that antenatal care and maternity services are a key development area.

Most services aim to cover both inpatient and outpatient services. However, in practice the majority of patient contacts are on the ward. One service relies on a strict protocol to ensure consistency of service across hospital sites. At the time of the study, the service was operating a protocol for inpatients only, and was in the process of piloting an outpatient protocol with a view to expanding the service. In addition to providing patient support, most services offer cessation support to hospital staff as well, and a small number also offer support to family and partners of staff, although in some instances the former can represent part of the hospital’s occupational health remit.
3.4 Patient recruitment
Most services rely on two main methods to recruit patients, namely direct access and referrals from frontline hospital staff. A large proportion of advisers’ time is spent consulting directly with staff on the wards and in clinics to identify patients who require support. In some hospitals, advisers can also access patient notes. Time is also spent raising awareness of the service, and building and maintaining referral networks through a variety of methods, such as attendance at staff meetings, distributing service information packs and organising informal briefing sessions on the ward with small groups of staff to discuss the service protocol, referral procedures, provision of pharmacotherapies, etc. Most referrals are received via telephone, pager or voice message from front-line nursing staff. A smaller number via email. Paper transfer is kept to a minimum to make referrals as quick and straightforward as possible. A few services rely on referrals from pharmacy services to identify patients who are receiving pharmacological support. A smaller number of referrals are received from medical staff, although physicians sometimes authorise ward staff to make a referral on their behalf.

In addition to face-to-face communications, most hospital cessation services also use non-personal channels to raise awareness of the service and to facilitate self-referral. These include service messages and promotion of the service contact telephone number on the hospital radio and the staff Intranet, and distribution of service literature as inserts with personal correspondence such as wage slips and admission letters. All services report using more conventional media, such as posters and service leaflets placed in waiting areas and on wards and staff noticeboards, although some do not currently provide information materials in patient consultation rooms. Some services also use No Smoking Day as an opportunity to raise awareness of available cessation support. These same channels and devices are also used to promote the specialist community-based cessation services with which the hospital service is often linked. The value of these awareness-raising measures is difficult to quantify, although services report receiving relatively few self-referrals.

The number of referrals, including self-referrals and those recruited directly, varies considerably across the services. Larger services report between 10 and 40 referrals per week, and smaller rural services report between 1 and 5 per week. The largest service, covering six acute hospitals, reported receiving upwards of 50 referrals a week.

3.5 Patient support
Most behavioural support is provided on a one-to-one basis, usually on the ward, although two services also meet with patients in the service’s hospital base. Some services have experimented with holding hospital-based cessation clinics at fixed times, but attendance has been reported as disappointing. However, clinics have proved a successful method for supporting staff in quitting smoking.

All services provided brief advice, asking patients about their smoking, whether they wanted help with quitting, discussing ways of attempting to quit, etc., and most, with the exception of respiratory specialist nurse-led services, which have more limited resources, also provide follow-up visits and ongoing behavioural support for patients staying in the hospital for a significant period, or attending as outpatients. Follow-up sessions often focus on coping strategies and evaluation of pharmacological support. Most services undertake one or two follow-up sessions within the hospital setting, reflecting the patient’s average length of stay. The first meeting usually lasts longer, anywhere between 30 minutes and 1 hour, with follow-up visits being much shorter, normally lasting for 15 to 20 minutes. As well as providing support for patients, many advisers also work closely with doctors and nursing staff to identify the most appropriate form of
pharmacological support, and with one exception, all of them also make onward referrals to community-based services, with around half arranging appointments for patients in advance of discharge. The one exception was a research-based project in which support was provided by project staff.

3.6 Pharmacological support
Pharmacological support is an integral component of the treatment provided by all hospital cessation services. A range of pharmacological therapies are stocked by hospital formularies. These are mainly NRT, although three services also report formularies stocking bupropion (Zyban) and two services report them stocking varenicline (Champix), with one service planning to introduce varenicline shortly. Around half of hospitals also maintain a more restricted stock on the wards, often for emergency purposes for use when the hospital pharmacy is closed.

Most hospitals prescribe NRT to patients either as part of a quitting attempt or as a temporary abstinence measure to help to deal with nicotine withdrawal symptoms while the patient is confined in hospital. All services also report hospitals prescribing a supply of NRT to patients upon discharge. Around half prescribe a 7-day supply and half a 14-day supply. Nearly all prescribing decisions are made by medical staff or independent nurse prescribers, with cessation specialists having an advisory role. In one service, the lead cessation specialist has recently qualified as a nurse prescriber and has the authority to dispense pharmacotherapies to inpatients.

Although most services also provide cessation support for staff, only three of the 15 services prescribe staff NRT as part of a quitting attempt. Two others operate a voucher scheme whereby staff can reclaim the cost of NRT. The remainder advise staff on choice of pharmacological support and how pharmacotherapies can be accessed in the community, and in some instances hospital advisers follow this up with a letter of request to the staff member’s GP.

3.7 Referral to the community
Inpatients form the largest client group, and are generally referred to community services for ongoing support, although in some rural board areas support is provided by the same advisers, whose time is split between the hospital and the community. One service has no pathways into the community, and provides all ongoing support from the hospital base. This particular service formed part of a time-limited research project.

Patients are generally referred to a generic community-based service – that is, specialist community services, GP-led services or services provided by community pharmacies. In most cases patients are offered more than one referral option, and in one or two instances support is combined – for example, with the specialist community cessation service providing behavioural support and community pharmacists providing access to pharmacotherapies. In most instances the majority of hospital referrals are made to the specialist community service, as strong links often exist with these services, and in some areas specialist community and hospital services can form separate parts of a single overarching service.

Although most hospital services refer patients to generic community services, two services offer telephone support options specifically for hospital patients and not available to other smokers. In one instance, telephone support is provided by the hospital-based service and in the other it is provided by specialist community services. Some specialist community services to whom patients are referred also accommodate patients who are housebound by making home visits, although this kind of support is particularly resource intensive and does not always form part of the formal service protocol. Consequently, availability of home support can vary according to other demands placed on the service.
Nearly all services have established referral pathways into the community, with referral procedures tailored to fit with the local service infrastructure. Rapid referral is considered important for maintaining the patient’s motivation and an unbroken supply of NRT, and for minimising drop-out rates. However, this is not always easy to achieve, especially where follow-ups are dependent upon a rigid appointment structure. Telephone support generally offers greater flexibility and a more rapid means of follow-up, while ‘seamless’ services set up to ensure that the same adviser follows the patient into the community are generally regarded as the service ideal.

Patient referrals are generally made by the hospital advisers or service administrative staff, although some services also rely on frontline nursing staff to make referrals or to direct patients to community services. In order to ease the transfer of patient information between services, most hospital services rely on a variety of communication methods, with some hospital advisers making contact with the community service by telephone in the first instance and then following this up with paper transfer. Some services are also experimenting with electronic information transfer and shared databases, although the evidence suggests that many of these systems are still at a developmental stage and require further refinement and testing.

Finally, the volume of onward referrals varies according to the level of dependence placed on community services to provide ongoing support and the overall size of the hospital service, with some smaller services making less than 5 community referrals a month, and the largest service making around 120 referrals over the same period. Most services make between 10 and 40 referrals a month. In some instances community services do not collect data on referral source, and where data are collected they are often not routinely analysed. Consequently, there is very little information available on uptake of cessation support in the community, although anecdotal evidence indicates that this is a critical area with high drop-out rates.

3.8 Training

All hospital services, with one exception in a rural health board area, provide or have access to training for frontline staff in smoking cessation. Nine services provide 1-day brief advice training and three services provide more intensive training of the type developed by the Maudsley Clinic, with two services providing both. Most hospital advisers also receive regular training updates. Training can be provided either in the hospital or off-site. In the latter case, participants can be from a range of healthcare settings. In most services, training is delivered by specialists or senior staff from the area’s smoking cessation service, in some instances with the local hospital adviser in attendance, because training courses are seen as an important opportunity to build links with key frontline staff. The majority of services provide training courses on a periodic basis, ranging from once to six times a year, although provision can vary depending upon need. For example, recent changes in smoke-free provisions prompted some services to offer additional training support, and the planned expansion of cessation support into specific hospital departments or services can have a staff training component.

Training is made available to a broad range of hospital staff, with ward and nursing staff being the groups most likely to have received training. Few services regularly record the numbers trained, and the available data are extremely patchy. The number of hospital staff who have received training over the last 2 years is described as disappointing, with the number trained by the majority of services in single figures. One service reported having trained in the region of 200 staff over this period, and another reported training 68 staff. The former figure includes hospital staff who attended weekly service briefing sessions, and is not comparable with the data provided by other services. Although other services undertake similar briefing work, they do not record these activities as training events.
A common barrier to increasing training uptake is the low priority attached to smoking cessation by hospital managers, with staffing levels and mandatory training requirements putting pressure on staff time away from the ward. Many services have attempted to overcome this problem by conducting informal briefing sessions on the wards, but the length of these sessions means that only certain core training elements can be incorporated. There is broad agreement on the need to make more resources available and to introduce smoking cessation training that is mandatory. Training for frontline staff is considered vital both for raising the profile of the service and for providing staff with the skills and confidence to raise the issue of smoking with their patients.

3.9 Monitoring
Patients’ smoking details are recorded in all hospitals, and are transferred to the patient’s case notes either at a pre-admission clinic, or more commonly at the time of clerking in, normally by an admissions nurse or doctor. In many instances this information triggers the referral process to the hospital cessation service, and can also be of value for assessing the correct dose and type of pharmacotherapy as a temporary abstinence aid or as part of an attempt to quit. Some services report potential referrals being missed or delayed, which can create real problems for advisers accessing patients and providing cessation support before they are discharged.

At the first meeting, advisers normally take a more complete smoking history, checking the patient’s carbon monoxide (CO) levels and assessing their nicotine dependence and motivation to quit, and in some instances obtaining the patient’s signed consent to collect and use data in line with the National Minimum Data Set database. All of this information is then recorded on the service’s database and updated as necessary. There are also occasions when advisers can request nursing staff to undertake additional monitoring, such as blood sugar levels in diabetics who are stopping smoking. Some advisers also make regular use of the hospital’s patient-tracking system to locate patients referred to the service as they move to other wards.

The majority of hospital cessation services, in partnership with community services, comply with the minimum dataset on monitoring outcomes, with data being collected at 4, 12 and 52 weeks post quit date. Some also provide non-mandatory information. In most instances these data are collected by the specialist community service, which often means that data for hospital referrals are either not collected or not analysed separately. There is currently no requirement to record hospital or secondary care as a referral source. The one hospital-led service retains responsibility for monitoring and enters these data into the national database independently.

3.10 Factors that inhibit and facilitate delivery
Analysis of questionnaire responses suggests that there are four key factors which inhibit and facilitate effective delivery, namely service capacity, management support, links with community services, and access to pharmacotherapies. Having sufficient staff resources to deliver a hospital-wide service emerges as the factor most likely to effect service delivery. In nearly all instances, resource limitations means that services are unable to realise their goal of providing hospital-wide support, with many struggling to provide basic cover for holiday, sickness and maternity leave. Inadequate administrative support and cross-site working further exacerbate these problems. Permanent funding, dedicated administrative support and securing a properly equipped service base within the hospital site contribute to more efficient working and the ability to retain experienced staff. Services report experiencing particular strain during the initial set-up phase, when staff are required to undertake developmental work at the same time as providing support to patients.
Securing the support of hospital management and senior medical and nursing staff is critical to service development by, for example, helping to establish a service base, facilitating access to wards and frontline staff, gaining permission to review patient case notes, obtaining extra clinic time, and providing protected time for hospital staff to take part in training. Those services that have been able to identify a clinical lead or ‘service champion’ have proved particularly successful in these respects, and staff in these hospital sites appear to attach a higher priority to smoking cessation.

Establishing good links and communication systems with community-based cessation services is essential in order to ensure that patients receive post-discharge support, as is the development of and agreement on a discharge protocol to allow a smooth transition into the community setting. Fully integrated services have particular advantages in this respect.

Finally, supply and access to pharmacotherapies can also act as barriers to service delivery. In many cases these problems have been largely resolved by working closely with clinicians and senior pharmacists. However, some newer services continue to experience problems, with some consultants unwilling to prescribe and some hospitals not maintaining supplies on the ward.
4. Descriptive case studies

This section describes the findings from an analysis of secondary care cessation services operating in six separate hospitals, four in Scotland and two in England. The services were identified as examples of cessation support in secondary care incorporating elements of promising practice. Contact details for each service are provided in Appendix 1.

Case 1 describes the local community service’s experiences of developing hospital-based cessation clinics in the Dumfries and Galloway Royal Infirmary, and examines the challenges of providing secondary care support in a rural context and the kinds of thinking involved in developing a dedicated hospital-based service.

Case 2 offers some insights into the value of a hospital-led service, with follow-up support provided by hospital-based advisers. The service, which is based and managed from Falkirk and District Royal Infirmary, also reveals some of the challenges of expanding the service to meet the smoking cessation support needs of the Stirling Royal Infirmary remotely from the Falkirk base.

Case 3 examines the work of a hospital-based cessation service in the Glasgow Royal Infirmary and its links with specialist services providing behavioural and pharmacological support in the community. The case study also examines the challenges of developing and running a city-wide service, and the values attached to the service protocol.

Case 4 looks at the experiences of a semi-autonomous hospital-based service in Wishaw General Hospital where the service lead aims to provide hospital-wide support. The case reveals the human dimension of service development and the importance of clinical support and adviser commitment to establishing a viable service.

Case 5 describes one of the first hospital-based smoking cessation services to be established in the UK, in Liverpool’s Cardiothoracic Centre. The service is provided by a full-time specialist adviser post funded by the hospital. The adviser not only treats patients pre-operatively as inpatients, but also follows them up in person and by phone after discharge. The case study explores some of the challenges of this type of service model.

Case 6 examines the secondary care smoking cessation service at Barts and the Royal London Hospitals. The service is fairly typical of smoking cessation provision in secondary care in England, in that a specialist adviser is employed by the local community-based (PCT) Stop Smoking Service, but provides cessation support to inpatients. The case study explores some of the advantages of this link with community provision, while also identifying some of the problems associated with working across several hospital sites.

The characteristics of each case are examined using eight service themes, namely service development, management and staff, targeting, referral within the hospital, provision of pharmacotherapies, referral to the community, monitoring and future development.

4.1 Case 1: Dumfries and Galloway Royal Infirmary

Dumfries and Galloway Royal Infirmary (DGRI), located in the town of Dumfries, is the only general hospital in the area and receives the majority of emergency admissions in Dumfries and Galloway. Cessation support in the hospital is provided by the region’s specialist smoking cessation service, Smoking Matters. At the time of the study, Smoking Matters was in the early stages of expanding the service to provide dedicated support for hospital patients at DGRI and one other smaller hospital, Galloway Community Hospital (GCH), located in Stranraer. This particular case examines the development of the service in DGRI.
4.1.1 Service development
Smoking Matters has been established for over a decade, and currently operates 30 weekly smoking cessation clinics spread throughout the region, offering one-to-one support by trained advisers. Most clinics are located in local health centres, although some utilise other public buildings such as local libraries, reflecting the rural make-up of the area. The service currently deals with around 200 new referrals a month, the majority of which are from primary care, with only a small proportion coming from DGRI and GCH. All clinic appointments are coordinated centrally from the service base in Castle Douglas.

All of the current cessation work in DGRI is conducted remotely and has a number of separate strands which have evolved over the last 5 years. These include awareness-raising activities, referral support, brief advice training and hospital-based clinics. The service recently distributed information packs to all of the wards in DGRI as well as in GCH, incorporating ‘mini-referral pads’ for nursing staff to complete with patients on the ward, and Smoking Matters leaflets and poster materials for display in public and staff areas. The service has also offered brief advice training to frontline staff in the hospital, but uptake is described as low, and the need to free staff from normal duties to take part is described as a significant barrier. It is believed that brief advice training should form part of the mandatory training that is received by all student nurses.

Another important development has been the piloting of a hospital-based smoking cessation clinic for inpatients and outpatients in DGRI, with funding from the National Lottery. The initiative received particular support from hospital management, who saw it as an important means of encouraging hospital staff to give up smoking – a priority issue at the time. Following the initial pilot phase, which attracted relatively few patients, the clinic was extended to provide a daytime base for local advisers to meet with clients living in the local area who were making a supported attempt to quit. In addition to the hospital-based clinic, Smoking Matters has also experimented with advisers attending respiratory outpatient clinics, where they were on standby to provide support on request. Again, however, the number of referrals received was low and the initiative proved unsustainable.

Following identification of the hospital setting as a priority area in the region’s 2006–2008 Tobacco Strategy and Action Plan, Smoking Matters used these experiences to devise a new approach to delivering cessation support in DGRI and GCH. A key feature of this approach was the realisation that the service needed to establish a permanent hospital base with dedicated cessation support if it was to provide a service properly adapted to the needs of patients and to the hospital’s healthcare delivery system. At the time of the study, Smoking Matters was in the process of designing and setting in place this new extension to the service. The remainder of this case describes the kinds of decision making and thinking that have been involved in bringing about these changes.

4.1.2 Management and staffing
The Smoking Matters strategic lead and service coordinator oversees the service’s team of nine cessation advisers, who work from different localities across the region, and four administrative staff, who work from the service base in Castle Douglas. Her chief responsibilities are acting as the strategic lead in tobacco control for the region, and operational management of the service. In addition to advisers working in specific localities, the service also employs two specialist cessation advisers, one working in pregnancy, who covers the whole region, visiting clients in their homes, and another with responsibility for young people, who works mainly in the school setting.

The new secondary care adviser post is the third post created by the service dedicated to working in a specialist area. Having an understanding and
experience of working in a hospital environment was considered to be an important prerequisite for developing the hospital-based cessation work, as was identifying a ‘local champion’ and gaining the support of senior hospital management. At the time of the study, the new appointee had been in post just 2 weeks, and the service was in the early stages of discussion to secure a service base in DGRI. Administrative support for the new hospital-based work will be provided from the main service base in Castle Douglas, a distance of around 20 miles from DGRI.

4.1.3 Targeting
Although the intention is to establish a hospital-wide service supporting both inpatients and outpatients, it is anticipated that it will initially target acute respiratory and coronary services and the medical receiving ward. It is estimated that around half of the patients using these services are smokers. Medical and nursing staff who work in these areas are acutely aware of the links between smoking and the many conditions that they treat, and regularly raise the issue of smoking with their patients, both on the ward and in their clinics. Although some of the specialist nurses working in respiratory medicine and cardiology have received brief advice training, the level of support that they are able to offer is necessarily restricted by other treatment priorities and the amount of time that they are able to spend with the patient. Consequently, there is broad support for having access to a cessation specialist on site to whom they can refer. As well as providing cessation support to patients, the new extended service will continue to offer support to hospital staff who wish to stop smoking.

4.1.4 Referral within the hospital
Although internal referral of patients by hospital staff is not a feature of the current smoking cessation service provided in DGRI, this situation will change once the specialist adviser is fully in post. It is anticipated that most referrals will initially come through the hospital’s respiratory service, an area which is well staffed (the service currently includes three respiratory nurse specialists trained to provide brief advice) and with whom Smoking Matters has established links. There is a belief that the new hospital-based cessation specialist will establish the visible presence needed on the wards to generate referrals. Dedicated support is considered particularly important to building commitment and to removing the current onus on frontline staff to make referrals directly to the service. One approach that is currently being considered is for the new secondary care adviser to make daily morning visits to the hospital’s main receiving wards in order to identify patients who wish for support.

4.1.5 Provision of pharmacotherapies
A range of pharmacological therapies are held in the hospital formulary, and an emergency supply of NRT patches is maintained on the hospital wards. These are prescribed by doctors and some nurse specialists who are qualified independent nurse prescribers. Although most therapies are dispensed to inpatients to manage symptoms of acute nicotine withdrawal, clinical staff sometimes prescribe a 1-week supply of the chosen therapy upon discharge for those patients who wish to attempt to quit. These prescriptions are currently paid for out of the hospital budget. Smoking Matters has a separate prescribing budget and has devised a patient group directive (PGD), which enables advisers to prescribe to clients attending the service’s clinics. The current payment structure will be reviewed as part of the ‘bedding-in’ process for the new expanded hospital service.

4.1.6 Referral to the community
Currently hospital patients either self-refer or are referred directly to the main service by consultants and nursing staff. Referrals are generally made in one of two ways. Nursing staff tend to rely on the mini-referral pads provided by Smoking Matters, while consultants usually make referrals by letter to the main service, with a notification note also sent to the patient’s GP as part of their discharge letter. DGRI has been experimenting with electronic
referral by email, but traditional pen-and-paper methods are currently favoured because access to computers is limited on the ward, and forms can be completed more quickly at the patient’s bedside.

The number of patient referrals to the main service using the existing system is described as ‘two or three referrals a month.’ The new expanded service aims to increase this to around 10 referrals a month in the first instance. Particular emphasis is being placed on reducing non-attendance or ‘did not attend’ (DNA) rates for cessation clinics at first appointment, which currently run at around 30% for the service as a whole. It is intended that DNA rates between the hospital and first clinic appointment will be reduced through enhanced access to the electronic fast-track referral system, which will improve the speed with which patients are picked up by the main service. It is anticipated that quicker referrals will facilitate greater continuity of service and an unbroken supply of NRT. The current system takes up to 2 weeks from discharge to first appointment. All clinic appointments for hospital patients will continue to be coordinated centrally, although where capacity permits it is also expected that the hospital-based adviser will follow up hospital patients seeking support upon discharge if they live within easy reach of DGRI, or if they express a wish to be seen in the hospital.

Hospital patients who are referred to the service’s cessation clinics will continue to receive the same cessation support as that received by other clients, unless they are housebound. All service clients are issued with an appointment for a clinic in their local area, and offered one-to-one, fortnightly support for a period of up to 3 months. First visits last about 40 minutes, and all ‘returns’ last around 15–20 minutes. On the rare occasions when demand exceeds supply, clinics offer group-based support. Hospital referrals who are unable to travel to a local clinic due to their medical condition will be offered home visits from an adviser where this is viable.

4.1.7 Monitoring
Smoking Matters follows the national guidelines for auditing quit rates. Patients who set a quit date while in hospital and then go on to receive support from the main service upon discharge are audited up to the 12-week point by advisers in the cessation clinics, and then at 52 weeks by administrative staff from the service base in Castle Douglas. These data are then entered into the National Minimum Data Set. There is also a field on the client monitoring form for recording referral source. This enables the service to break down the data for clients referred from secondary care, but does not provide detailed information on the source of referrals within the hospital by, for example, department or named individual.

4.1.8 Future developments
The current focus is on developing and bedding in the new expanded hospital-based service. However, work is also under way to introduce smoking cessation information into pre-assessment clinics for patients undergoing elective surgery. This will include written information about the hospital’s smoking policy and an explanation of how NRT prescribing and referral to the main service work.

4.2 Case 2: Falkirk and District Royal Infirmary
The Falkirk and District Royal Infirmary cessation service forms part of the hospital-based service covering the two main hospitals in NHS Forth Valley, namely FDRI and Stirling Royal Infirmary (SRI). The service provides cessation support for both inpatients and outpatients in both hospitals, and links with cessation support in primary care provided by GP surgeries and a specialist community-based drop-in service.

4.2.1 Service development
The service was established in 2002 as a 2-year pilot project in FDRI by a senior stroke consultant with funding from the Health Improvement Fund, and was later expanded to cover SRI with Breath of
Fresh Air funding awarded by the Forth Valley Tobacco Action Group in 2004. The current funding arrangement is due to run out in April 2008. [AQ7] The decision to extend the service to SRI followed a major restructuring exercise which resulted in all acute and emergency care services – a key referral source for the hospital-based service – being relocated to Stirling. The transfer of staff from FDRI to SRI as part of the restructuring exercise means that the cessation service has good working relationships with the hospital staff responsible for making referrals to the new expanded service.

4.2.2 Management and staffing
The lead smoking cessation nurse specialist has been with the project since its inception in April 2002, and her drive and endeavour have been a key factor in the service’s expansion. She has many years of experience in smoking cessation, and is a founding Chair of the British Association of Smoking Cessation Practitioners (BASCP), the national body for smoking cessation practitioners in the UK, which was set up by the British Thoracic Society. She has responsibility for the service’s two other cessation nurse specialists, and a part-time administrator who provides 10 hours of administrative support a week. Finding the necessary resources to run an efficient service is described as a constant battle. The service is overseen by the Director of Public Health, and has no departmental head within FDRI, which can make ‘fighting its corner’ and securing support difficult. Further expansion is constrained by available staff resources, and the lead cessation nurse specialist can sometimes find herself having to undertake basic administrative tasks, which reduces the amount of time that she can spend on patient support and service development.

The service has a permanent base with telephone and computer support in FDRI, but operates as a remote service in SRI, which can result in inequities in the level of support provided in each hospital. In practical terms, this arrangement means that the advisers are required to carry all their paperwork and materials when working on the SRI site. The service aims to see all patients from SRI within 2 days of referral, while most FDRI referrals are seen on the same day.

All three cessation nurse specialists work between the two hospital sites and provide cover for each other. Having a nursing background is seen to be an advantage when delivering cessation support in an acute setting, as it provides a better understanding of the patient’s condition, abilities and needs.

4.2.3 Targeting
The project was originally conceived as a hospital-wide service, covering both inpatient and outpatient departments. The service has gradually expanded its range of operation, but continues to rely on cardiac, respiratory and stroke admissions for many of its referrals. A small but significant proportion of referrals are hospital staff. In 2006, the service set up a pilot project with the support of the lead consultant anaesthetist to target patients undergoing elective surgery at pre-operative assessment clinics. The pilot trained pre-operative nursing staff using a purpose-designed training pack to provide brief advice and to facilitate onward referral to the hospital-based cessation service, community-based drop-in clinics and the patient’s GP. The results from the early pilot work are described as promising, although securing the support of primary care and gaining access to patients within the target period 6–8 weeks in advance of surgery have proved challenging.

4.2.4 Referral within the hospital
The service receives around 14 new referrals each week, of whom approximately 60% are inpatient referrals, 30% are outpatient referrals (including pre-operative referrals), with the remaining 10% consisting of staff referrals and a small number of self-referrals. Around 25% of referrals (a total of 133 in 2006) receive ongoing support from the hospital-based service as outpatients or by telephone.
The service currently relies upon frontline hospital staff to make referrals, normally by telephone or voice mail. A more proactive approach involving daily morning visits by the cessation nurse specialist to the main referring wards is seen as a more effective way of recruiting inpatients, but this is not possible given the service’s current capacity and the remote nature of the operation in SRI. The service regards all admissions as a ‘window of opportunity’, and treats both those motivated to quit and those who require short-term support to cope with nicotine withdrawal symptoms. Although inpatients are often more receptive to smoking cessation advice, advisers can find themselves competing for the patient’s time and attention, and recognise that treatment needs must take priority. Patients who are not ready to make an attempt to quit are provided with information about the community-based drop-in clinics should they wish to engage upon returning home.

Inpatient referrals who engage with the service are seen on the ward every 2 to 3 days, depending on their length of stay. The service does not follow a strict protocol, but the first consultation normally lasts about 40 minutes, with follow-up visits lasting around 20 minutes. Upon discharge, inpatients are offered telephone counselling, which provides up to 8 weeks of support delivered by a hospital-based cessation nurse specialist. Some patients choose to be seen in the hospital base at a time that coincides with their outpatient appointments. Telephone support is seen to have a number of advantages. It provides a practical alternative to home visits which are not viable within the service’s existing budget, and it provides a seamless link between the hospital and the community, with support being provided by the same cessation nurse specialist.

The majority of outpatient referrals are from cardiac and respiratory departments. Patients are contacted by telephone, normally within 2 days; contact by letter is regarded as too slow and impersonal. If the patient chooses to take up the offer of support, an appointment is arranged to meet with a cessation nurse specialist in the FDRI service base at a time to fit around their outpatient appointment, and weekly telephone support or on occasion one-to-one support within the service base is provided thereafter for a period of up to 3 months if requested. The service originally experimented with group-based support, but this proved unworkable due to high rates of drop-out. In some instances support is also provided to other family members and partners. In addition, the service operates an outpatient clinic at set times at the SRI site.

To help to promote referrals and improve the level of cessation support, the service has made a number of attempts to provide brief advice training for ward nursing staff, but has experienced real challenges in securing staff time to attend. More informal briefing sessions in the form of either working lunches or meetings held on the ward at times convenient to staff have been found to be a more effective means of raising awareness of the service. Attempts have also been made to incorporate training into the staff induction day, but mandatory requirements have made this approach unworkable. The service leaflet is now included in the staff induction pack. There is a belief that brief advice training needs to be incorporated as a mandatory part of staff training.

4.2.5 Provision of pharmacotherapies
Both FDRI and SRI stock a range of pharmacological therapies on the hospital formulary. Therapies are also held on the wards, although limited availability of space mean that stocks can vary, which can result in treatment delays, particularly at weekends. All prescription decisions are made by medical staff, with cessation nurse specialists having an advisory role. NRT is the therapy of choice, largely because therapeutic levels can be achieved relatively quickly compared with other therapies. Pharmacological therapies are often prescribed for patients confined to the ward who are experiencing symptoms of acute nicotine withdrawal.
Upon discharge, patients are prescribed a 1-week supply of NRT, and the cessation nurse specialist writes to the patient’s GP requesting continuation. A number of cases were reported of GPs challenging the hospital’s recommendation, which may suggest the existence of a gap in GP training. There is also a provision in the PGD to prescribe NRT to hospital staff who wish to attempt to quit.

4.2.6 Referral to the community
Patients who are resident in the Forth Valley NHS Health Board area have access to three main forms of behavioural support, namely referral to primary care with ongoing support provided by the patient’s GP, self-referral to the health board’s community drop-in service, or weekly telephone support provided by a cessation nurse specialist in the hospital-based service (see ‘Referral within the hospital’ above).

The service makes around 10 community referrals a month, most of which are to the patient’s GP. The lead cessation nurse specialist maintains a directory of practice nurses and health visitors working in primary care in the area who have been identified as GP-based community advisers. The cessation nurse specialist normally sets up an initial appointment with the GP practice adviser by telephone prior to the patient being discharged, and later forwards by post the patient’s details, including level of dependency, amount smoked, pharmacological support, etc. The nature of the training received and support offered by practice staff is described as variable. On discharge of the patient, their GP is also sent a letter requesting ongoing pharmacological support if appropriate. There is little direct communication with the GP unless problems arise.

The community service operates weekly drop-in clinics in three health centres located in the health board’s three main urban areas. The clinics are run by trained advisers who are able to offer 4 weeks of intensive behavioural support coupled with free pharmacological support.

4.2.7 Monitoring
The hospital-based service audits all those patients who are receiving ongoing cessation support provided by the service. Audits adhere to the national guidelines for follow-up at 4, 12 and 52 weeks, and include an additional follow-up at 26 weeks. The majority of follow-ups are conducted by telephone by the cessation nurse specialist. The most recent complete figures at the time of the study (April 2005 to March 2006) indicate a CO-validated quit rate of 39% at 4 weeks and self-reported quit rates of 36% at 12 weeks and 8% at 52 weeks (n = 131). Patients who use the community drop-in service are audited separately and the data are transferred to the national database. The nature and scale of auditing undertaken by GP practices is unknown, and no data are collected on attendance levels for patients referred to primary care.

4.2.8 Future developments
A primary objective of the hospital cessation service is to secure funding to establish a permanent base on both hospital sites with a view to moving to a new single hospital site, planned for 2009. It is anticipated that these developments will form part of an integrated Forth Valley Smoking Cessation Service. The service is also exploring ways of developing its links with maternity services to provide specialist support to pregnant mothers and their partners, and is examining the possibility of expanding the service to cover the new mental health ward in FDRI.

4.3 Case 3: NHS Greater Glasgow and Clyde Smoking Cessation Service – Glasgow Royal Infirmary
The cessation service in Glasgow Royal Infirmary (GRI) forms part of a centrally coordinated city-wide service offering cessation support to inpatients in all six acute hospitals in Glasgow. The service is typical of that offered in the other participating hospitals in the city.
The service as a whole is coordinated by Smoking Concerns, the health board’s specialist tobacco team, and is divided into two geographic divisions, the north and the south, each with its own nurse manager. GRI covers the north east of the city, which is the area with the highest rates of deprivation and smoking, and is one of the city’s largest hospitals. The service links or shares care with NHS community specialist cessation services that provide ongoing behavioural support for the quit attempt, and the Starting Fresh service which provides pharmacological support and brief advice through an extensive city-wide network of community pharmacies.

4.3.1 Service development
The development of a hospital-based service followed the establishment of the community- and maternity-based cessation services in the city. The service lead came into post in 2004 and has been responsible for the development of the service. A key element of the service is the protocol, which underwent an intensive 6-month pilot in 2005 in a hospital in the south of the city to test the recruitment and referral procedures and to establish the prescribing system. The full service was then rolled out across the city in January 2006, and had been operational for 18 months at the time of the study.

The service protocol classifies patients into three levels according to need. Level 1 patients are not ready to quit, Level 2 patients require temporary support due to acute nicotine withdrawal symptoms, and Level 3 patients are motivated to stop smoking and wish to set a quit date. The service is specifically designed to support Level 3 patients by providing a referral pathway and pharmacological support into the community. Level 1 and 2 patients are provided with information about Smoking Concerns general cessation services to support future attempts to quit.

The development of a standard protocol has been critical to the service’s success. More specifically, it has been responsible for overcoming many of the organisational challenges involved in bringing together different service components and in establishing a city-wide service. In addition, it provides a means of ensuring equitable support for service users, and enables advisers to move between hospital sites to provide staff cover in order to maintain the service.

4.3.2 Management and staffing
The service has bases in all six hospital sites, with funding guaranteed to 2009. The majority of advisers are from non-health backgrounds, which can pose challenges. To help to overcome these, the service has devised a comprehensive induction programme incorporating additional mentoring and training.

The GRI service is based with the cardiac rehabilitation team and currently operates with one full-time and one part-time adviser, and part-time administrative support. The service also includes provision of cover for referrals from one other hospital in the north division, Stobhill Hospital. Resource constraints have meant that the five advisers currently employed by the service need to work across hospitals in order to provide cover, with travel between sites causing some inefficiencies.

The hospital adviser works closely with the smoking cessation coordinator for north Glasgow, to whom she makes most of her referrals. The smoking cessation coordinator is based at Maryhill Health Centre, and is line managed by the health improvement team for the North Glasgow Community Health and Care Partnership. Both advisers are in regular telephone contact and take part in joint meetings. The smoking cessation coordinator also spent a day shadowing the hospital adviser in order to familiarise herself with the service.

4.3.3 Targeting
The service aims to provide a hospital-wide service with equitable access for all inpatients. In practice,
the majority of referrals are from cardiology and respiratory wards, where smokers form a higher proportion of patients and are often heavily addicted. Experience suggests that some areas and departments are ‘harder to crack’ than others (for example, surgery and orthopaedics), although this can vary between hospitals. The service undertakes careful monitoring of referral sources in order to identify and target areas of low activity. Although advisers are trained to provide cessation support, they see their primary role as identifying individuals with heightened motivation to stop smoking, helping to initiate a quit attempt and providing a clear pathway to community services. There is also a drop-in service for staff in GRI, which is held in the occupational health department and staffed by the hospital adviser. This is a city-wide initiative working with the occupational health department to support staff in stopping smoking.

### 4.3.4 Referral within the hospital

A key and ongoing function of the GRI hospital adviser is to raise awareness of the service among frontline nursing and medical staff and their immediate managers. This is largely achieved by building links with ward staff and by arranging and running informal service briefing sessions. These awareness-raising activities are complemented by brief advice training, which is provided by the training officer at Smoking Concerns. Advisers are discouraged from actively seeking referrals directly by ‘walking the wards’, as full and equitable coverage of the hospital cannot be guaranteed using this kind of approach. The focus is on equipping all NHS personnel to signpost motivated smokers to the service.

Using these approaches, the GRI adviser receives on average around four new referrals each day, the majority of which are made by nursing staff. Referrals are either called directly through to the adviser, or left by voice message. The referrer is not required to complete any paperwork as part of this process. Changing the practice of personnel to include asking, recording and referring smokers has been a major challenge for the service. However, the focus has gradually changed towards ensuring that the service attracts appropriate referrals at Level 3, as opposed to Level 1 and 2 referrals. The latter tend to be made by or on behalf of medical staff, and are attributed to the nature of the doctor–patient relationship and doctors’ questioning style. Appendix 2 illustrates the inpatient stop smoking care pathway and staff reminder card used by the smoking cessation advisers in GRI and other hospitals that form part of the NHS Greater Glasgow and Clyde hospital cessation service.

The average length of stay for hospital patients is around 3 days, which means that most Level 3 patients receive two consultations, although longer-stay patients can receive one, and in some instances two, consultations a week. The first consultation, which can last up to an hour, is used to examine the patient’s smoking history, assess their nicotine dependence and motivation to quit, discuss the support options available in the community (including pharmacological support) and obtain written consent for the transfer of personal data between service providers. A second shorter consultation, or ‘return’ the following day, is used to check that pharmacological support has been prescribed and to assess the patient’s ability to administer the treatment. Hospital advisers are not currently allowed to carry NRT product samples, so a product demonstration is normally only possible once the product has been dispensed. All hospital consultations take place on the ward, either at the bedside or in the patient lounge.

### 4.3.5 Provision of pharmacotherapies

All prescriptions for inpatients are issued by doctors, with the hospital cessation specialist having an advisory role. An outline of the patient assessment protocol is illustrated in Appendix 3. The first-choice product is the 15-mg, 16-hour Nicorette patch.
Gaining the support of senior medical staff has been important for ensuring that pharmacotherapy is made available throughout the hospital, although some departments and physicians can be resistant. All Level 3 patients are discharged with a 2-week supply of NRT, which is free if they are exempt, or at prescription cost, and up to the full 12-week course of treatment, which they can collect weekly from a Starting Fresh community pharmacy in their local area. Starting Fresh pharmacists and counter assistants are also trained to provide brief advice lasting for 5–10 minutes per consultation. The evidence from this case study indicates that counter assistants derive more benefit from the training received and are more likely to assume an active advisory role, although patients’ willingness to engage can be variable. Some patients request fortnightly or monthly prescriptions, and pharmacists will occasionally make a concession to accommodate holiday breaks, etc. For patients who are housebound, an instruction is sent to their GP to continue the recommended pharmacological treatment.

4.3.6 Referral to the community

A key role of the hospital adviser is to arrange support for the patient when he or she returns home, with ward visits coordinated around the discharge date to ensure that the patient is prepared for coping at home and has been prescribed a supply of NRT to take away with them. Two forms of support are made available to Level 3 patients in the community, namely a 12-week supply of NRT and brief advice from a local community pharmacist (for further details, see ‘Provision of pharmacotherapies’ above), and 4 weeks of more intensive telephone support from a specialist cessation adviser working in the community. The hospital adviser contacts both the community pharmacist and the community adviser by telephone immediately after discharge to pass on the patient’s details. A follow-up letter containing the client record card (including quit date), contact details, chosen pharmacotherapy, etc. is also sent to the community adviser, and in addition an information letter is sent to the patient’s GP. Hospital advisers have no active role once the patient has been discharged.

Patients who sign up with the service are followed up by telephone by a local smoking cessation coordinator (who is trained in the use of telephone support) within 2 days of discharge. Drop-out rates are described as high at this stage, although the GRI hospital adviser has found that patients are more likely to engage with the service if staff continuity is retained between the hospital and the community. Those contacted receive up to four weekly calls to review their progress, discuss coping strategies and assess use of their pharmacotherapy. Calls are normally made at the same time each week as agreed by the patient, and usually last 15–20 minutes. Occasionally, patients will ask to meet the adviser in the community health centre and/or will be offered access to a support group where practicable. Support groups form part of the mainstream community service. Completed record forms are returned to Smoking Concerns after 4 weeks. In addition, patients who drop out during this period are sent written details of the community cessation service in case they wish to re-engage in the future.

4.3.7 Monitoring

Monitoring the impact of a city-wide service covering six separate sites presents particular challenges with regard to managing patient data, not least of which are the difficulties of merging different databases. Smoking Concerns has recently employed a full-time data manager to help coordinate this task.

All Level 3 patients who have set a quit date are followed up by telephone at 4, 12 and 52 weeks, the first assessment being made by the patient’s smoking cessation coordinator, and the second and third assessments conducted centrally by Smoking Concerns.
Concerns. No data were available for the 12- and 52-week follow-ups at the time of the study, although the 2005 pilot achieved a self-reported quit rate of 57% at 4 weeks for those who were not smoking at discharge. The equivalent rate from the full roll-out to December 2006 is 34.2%. Anecdotal evidence suggests that community cessation service users have more sustained motivation to quit than hospital referrals, whose desire to quit can quickly decrease once they return to the familiar patterns of home life.

4.3.8 Future developments
The inpatient service had been running for 18 months at the time of the study, and the focus has been on bedding in the service and refining the protocol. There are plans to extend the service to outpatients. Hospitals in the north division are involved in a pilot project which is working with selected outpatient clinics to fast-track patients to cessation support in the community. There are also plans to integrate the service with hospitals serving the Clyde area as part of the recently established NHS Greater Glasgow and Clyde.

4.4 Case 4: Wishaw General Hospital
Wishaw General Hospital is located in a high-deprivation urban catchment with high rates of smoking and chronic illness, and is one of two hospitals in Lanarkshire currently providing dedicated cessation support. There are plans to develop the service in one other hospital in the area. The support provided in the two active hospitals is based on the same service model and forms part of an integrated pan-Lanarkshire service consisting of eight localities and three acute hospitals. The Wishaw service employs one full-time clinical nurse specialist adviser who works exclusively in the hospital.

4.4.1 Service development
The service was piloted in 2003 under the stewardship of the hospital’s senior respiratory physician, and has gradually expanded to become a hospital-wide service. This expansion is due in large measure to the commitment and effort of the clinical nurse specialist, who has been with the service since its inception and has been responsible for devising and refining the service protocol in conjunction with the hospital-based clinical nurse specialist working in Monklands Hospital. She has a community nursing background, with previous experience of delivering cessation support in the community setting, and a Masters degree in health promotion and health education. The senior respiratory physician continues to act as the clinical lead and ‘champion’ for the service, and is currently the hospital’s medical director. In recognition of their work, the hospital and community services were integrated in 2006 to form the NHS Lanarkshire smoking cessation service.

4.4.2 Management and staffing
The cessation adviser was initially employed on a full-time fixed-term contract and, following the integration with the community service, took up a permanent post with Lanarkshire NHS. She continues to operate on a semi-autonomous basis, but maintains regular contact with the other hospital and community advisers. The service operates from a private office within the hospital, and has secured 16 hours of administrative support a week to manage the patient database. This has enabled the adviser to spend her time more efficiently by treating patients, although further administrative support is being sought. Operating as a single practitioner can create problems with provision of cover during holiday periods and weekends. To try to address this and other resource shortfalls, the service has recruited around 10 ‘link nurses’ from key departments who are able to deal directly with the community service as required. These are often nurses who have undergone brief advice training and/or who have used the service themselves to give up smoking and have expressed a particular interest in supporting cessation activity. In addition, the service includes a “buddy system” supported by patient volunteers who have given up smoking as a result of using the service. Buddies visit patients in the ward and also offer telephone support on discharge.
The clinical nurse specialist's primary roles are to refer outpatients and those being discharged on to the community service, to provide intensive support for inpatients who are motivated to stop smoking, and to make available information on stopping to the wider patient population. Time is also devoted to maintaining the referral network, where she regularly attends and arranges internal staff meetings and working lunches. In addition, she has responsibility for delivering brief advice training to frontline hospital staff using a training pack approved by Partnership Action Tobacco and Health (PATH). The clinical nurse specialist supports these training sessions by working closely with nursing and ward managers to help to secure participants’ release. Efforts have also been made to build smoking cessation into the staff induction programme. However, these have largely been abandoned due to pressures on hospital management to meet a growing range of statutory requirements.

4.4.3 Targeting
Although the service operates on a hospital-wide basis, the majority of referrals come through respiratory and cardiology wards, where many are acute patients receiving emergency care. Good links with the consultants and nursing staff in these departments have been essential to the service’s success in these areas. Referrals are also received through surgical wards, elderly care, the stroke unit, intensive care, emergency receiving wards, the Accident and Emergency unit and pre-assessment. Many of the patients seen by the service are heavily medicated and receiving intensive treatments. Consequently, limited patient mobility means that pharmacological support is often provided to deal with acute nicotine withdrawal symptoms and disruptive behaviour, although for some patients this can translate into a quit attempt with the adviser’s support. The recent ban on indoor smoking has enhanced the need for this type of support.

Patients who are referred through outpatient departments are often those who have relapsed following a hospital admission, and it is not unusual for the same patient to make repeated attempts to quit during their journey through the healthcare system.

The service also provides cessation support to staff on a drop-in basis. Successful quitters have been found to be important advocates for the service within the hospital. However, resource pressures have meant that staff are sometimes directed to the community cessation service.

4.4.4 Referral within the hospital
The service receives 10–30 referrals a week depending on the time of year. Winter is the busiest period due to an increase in admissions of patients with chronic chest conditions. Most referrals are from nursing staff working on the acute wards and from a smaller number of clinical staff who are enthusiastic supporters of the service. The service also receives a small number of self-referrals, which are triggered by the many information posters and leaflets distributed throughout the hospital. Maintaining demand for the service has been largely dependent upon establishing a strong referral network, which involves working with both frontline staff and their line managers.

Given the relatively short stay of many patients, which in some instances can be less than 24 hours, staff are encouraged to phone through referrals or to page the clinical nurse specialist directly on identification. Less reliance is placed on paper referrals because of the time this adds to the referral process and the extra burden it imposes on staff to complete referral forms. Prior to the appointment of the specialist adviser, nursing staff were instructed to refer patients who were motivated to quit directly to the community, which could be time consuming and meant that patients were more likely to slip through the net. The arrival of the clinical nurse specialist has both given staff the confidence to ask patients about their smoking, and removed the administrative burden of making a referral. In addition, it means that patients now receive specialist support in a more timely manner.
The clinical nurse specialist will treat those who have expressed an interest in quitting as well as those who require temporary support. She normally follows up referrals on the ward on the same day, and then visits on a daily basis as appropriate if the patient expresses a wish to quit. The first consultation, including an assessment with the ward nurse, can last up to an hour, with follow-ups normally lasting about half that time. The support offered varies according to the needs and abilities of the patient and the amount of time available, although the adviser makes regular use of CO monitoring as a motivational aid. Patients who do not wish to quit are given a copy of the service leaflet, which provides information about accessing support in the community.

**4.4.5 Provision of pharmacotherapies**
Pharmacological therapies are a key feature of the service. The clinical nurse specialist helped to devise a patient group directive (PGD) for the area in conjunction with the senior community pharmacist, and as one of the first hospital-based cessation nurse specialists in Scotland to have undergone pharmacological training, is qualified as an independent extended nurse prescriber. Because she can prescribe independently, this ensures that patients are treated quickly and receive the product which best meets their needs. The hospital formulary carries a range of pharmacological therapies, including NRT and varenicline, and emergency supplies of NRT are held on the wards. These are prescribed in accordance with patient needs, although the standard prescription is the NRT 24-hour patch. Pharmacotherapies can be prescribed by the clinical nurse specialist to support an attempt to quit or to deal with acute nicotine withdrawal symptoms, and in some instances therapies have been prescribed to help mental health patients who are trying to cut down. Having a health background has been found to be an important asset in gaining the support and trust of medical staff.

Originally, patients who were attempting to quit were prescribed 1 week’s supply of NRT on discharge. However, this was sometimes found to be insufficient to cover the period between discharge and being picked up by the community service, and has since been increased to a 2-week supply. The community service is also able to prescribe NRT as part of the PGD. However, with cases not covered by the PGD, most notably heart attack or acute MI cases, licensing issues have meant that community advisers have to obtain GP consent in order to prescribe. In most cases, obtaining consent is relatively straightforward, but there are cases where the GP disagrees with the consultant’s recommendation. Such cases can place further demands on the service to secure a continued supply of NRT, and would appear to indicate a need for additional GP training.

**4.4.6 Referral to the community**
The service makes between 50 and 60 referrals a month to the community, most of which are to the specialist community cessation service, with which there are strong links. The community service is well established, having been in place for over 5 years, and offers group-based support and home visits for patients who are housebound due to their medical condition. Hospital referrals form a small but significant proportion of the community service’s patient load, most of which are GP or self-referrals. Patients who do not wish for home or group support are offered the option of referral to their GP, as are patients who live outside Lanarkshire, although in some instances the specialist adviser makes referrals to other specialist community services in adjacent health board areas, where these services exist. In all instances the patient’s GP is sent a letter informing them of the support options taken up, and a copy is saved in the patient’s hospital notes for reference.

A shared electronic database means that the community service has the capacity to access patient information directly. However, data protection
issues have meant that the service is currently relying on paper transfer, which can introduce inefficiencies. Consequently, referrals to the community service are normally phoned through to the relevant locality in the first instance, and community advisers normally establish contact with the patient within 2 to 3 days of discharge. Speed of contact is considered crucial both to retaining continuity of service and to sustaining the patient’s attempt to quit, as motivation can rapidly dwindle once the patient reconnects with their normal home life. Initial contact is normally made by the community adviser by phone to assess the patient’s commitment to quitting, and to discuss support options. The community service also provides support to other family members who choose to quit as part of a shared attempt. For those who drop out, service information is provided to facilitate contact should they wish to re-engage at a future date. Once the patient has been discharged, the hospital cessation nurse specialist has no further role, although contact is sometimes maintained through the patient’s attendance at outpatient clinics, and in some instance patients may re-engage with the service following a repeat admission.

4.4.7 Monitoring
The hospital cessation nurse specialist’s record keeping contributes to the Scottish MDS. [AQ8] However, ongoing monitoring is the responsibility of the community cessation service, which follows up patients who have made an attempt to quit. Post-intervention monitoring is performed by telephone, or by prepaid letter in cases where telephone contact is not established. GP monitoring of quit rates of patients under their care is described as variable.

Although the capacity exists, the cessation service does not routinely report quit rates for hospital referrals. However, results from the initial pilot in 2004 achieved a 25% CO-validated quit rate at 12 months. Monitoring of hospital referrals can be complicated by the fact that quit dates coincide with periods of intensive medical treatment, when pharmacological therapy can be initiated as part of the patient’s general care plan to manage the symptoms of acute nicotine withdrawal.

4.4.8 Future developments
The service is involved in a number of developments. Various developments are under way in midwifery, including a midwife referral pathway, brief advice training for midwives, and more extensive use of CO monitoring during pregnancy. Another priority area is patient monitoring. The service is currently improving the accuracy of the patient database in order to identify gaps in the hospital referral network and to enable more effective targeting of training resources. The clinical nurse specialist is also in the early stages of assessing the potential for developing an integrated care pathway (ICP) for smokers, which will help to ensure more dedicated cessation support throughout the patient’s healthcare journey from initial admission, through to discharge and then onward into the community, with follow-up for 1 year. Again, these developments are likely to provide insights that will be of value to others working in the hospital setting.

4.5 Case 5: The Liverpool Cardiothoracic Centre
The Cardiothoracic Centre (CTC) Liverpool NHS Trust is one of the largest specialist heart and chest hospitals in the UK. It is located in south Liverpool, and provides care to patients from across North-West England, including North Wales and the Isle of Man. The hospital provides services in five areas of clinical expertise, namely cardiac surgery, thoracic surgery, cardiology, respiratory medicine and upper gastrointestinal surgery. The trust employs a smoking cessation adviser who provides treatment for patients in hospital and in the community.

4.5.1 Service development
The CTC was one of the first hospitals in the UK to
establish an in-house smoking cessation service. This was initially developed in the early 1990s under the leadership of a lung cancer surgeon. In 1994, the hospital appointed a specialist smoking cessation adviser who is still in post. In addition to service delivery, she has a remit for smoking cessation training both within the hospital and in the community. She provides some external training to smoking cessation services in other parts of Merseyside and elsewhere in the UK, and is also active in national tobacco control networks, including serving as a board member for ASH in England.

4.5.2 Management and staffing
The smoking cessation adviser is employed by the CTC. This is a slightly unusual model in that most hospital-based smoking cessation provision in other parts of the UK is provided by staff who are employed by community smoking cessation services, even if they have a hospital base. The smoking cessation adviser works 30 hours a week. Her working hours have gradually risen from 22.5 hours a week when she was first appointed. Although she is well supported within the hospital and has well-established relationships with a wide range of colleagues, she operates as a single practitioner and does not have any dedicated administrative support or other colleagues in a similar role. When she is on leave there is no cover within the hospital. This means that patients who are referred when she is away have to wait to see her either in hospital, or once they have returned home or are referred by hospital staff to their local community smoking cessation service.

4.5.3 Targeting
Smoking cessation support is available to patients in all parts of the CTC. Interviews with a range of hospital staff, from consultants to cardiac rehabilitation and respiratory nursing staff, revealed that knowledge and use of the service are extensive. Because of the conditions treated within the hospital and their link to smoking, combined with the high prevalence of smoking in Liverpool, a high proportion of patients are smokers. At the time of the research, the smoking cessation adviser was receiving up to 50 new patient referrals each month. Demand had risen since the hospital became completely smoke-free, and since the introduction of England’s smoke-free legislation earlier in 2007. At the time of the study, the adviser was struggling to cope with the volume of referrals.

4.5.4 Referral within the hospital
The CTC has a well-established referral pathway to the specialist adviser from all parts of the hospital, including pre-operative clinics and outpatient departments. All new patients, whether attending for a procedure or pre-operatively, should be asked about their smoking status. If they are still smoking, a high proportion of nursing and medical staff have received training (usually from the specialist adviser) to deliver brief advice to them, and will do so. They then ask for the patient’s consent to refer them on to the adviser. If consent is granted, a referral is made to the adviser either by phone, email or, in some parts of the hospital, by making a note in a referral book which the adviser can access. If the adviser is in the hospital, the patient can often be seen immediately or on the same day. A priority is to see pre-operative patients in order to support cessation before their operation.

Once a referral has been made, the adviser sees the patient either in hospital or at home. Home visits take place for pre-operative patients whom the adviser was unable to see when they attended the CTC for their pre-operative appointment, for patients who were discharged before the adviser could see them, or for patients who are being followed up at home after an initial treatment session in hospital.

The treatment model adopted by the adviser is flexible and is based on the needs of the patient and the adviser’s available time. Most patients are seen initially in hospital for a minimum of 30 minutes. The second appointment then takes place either in hospital, at home or by telephone. In most
cases it takes place at home, and is usually 2 to 3 weeks after discharge. As the CTC treats patients from a very wide area, some follow-up takes place only by telephone, although the adviser will travel as far afield as North Wales to see a client at home. Treatment then continues for up to 10 weeks, with subsequent support usually provided by telephone, although again this does vary. The adviser often supports partners or family members in quitting along with the patient.

4.5.5 Provision of pharmacotherapies
Pharmacological support is available through the hospital formulary and as part of ward supplies. Medical staff will provide patients with pharmacological support on the ward as part of an attempt to quit, to support a patient who stopped smoking before they were admitted, and also to deal with nicotine withdrawal symptoms. Once the patient has been referred to the adviser, she is able to facilitate access to a pharmacotherapy after discharge. She either distributes vouchers to clients before they go home or, if they have already received a prescription from medical staff in the hospital, provides NRT after discharge either by voucher or by delivery of the product, depending on where the patient lives. This voucher system operates across all of Merseyside’s primary care trusts (PCTs), and is used by all local community-based smoking cessation services. The PCTs cover the cost of the prescription through a negotiated top-slice of the primary care pharmacy budget. The CTC smoking cessation adviser gives clients NRT vouchers that are colour coded depending on the PCT area in which they live. If they come from outside Merseyside, the adviser has an agreement with Liverpool PCT to provide their vouchers to these clients. If the adviser sees the patient once they have returned to the community, she provides them with additional vouchers for up to 12 weeks after the quit date.

Patients who are seen by the adviser do not normally use bupropion or varenicline in hospital. However, an increasing number of patients are requesting varenicline, and in such cases the adviser will phone the patient’s GP to ask them to prescribe it after discharge.

4.5.6 Referral to the community
The CTC adviser follows up the majority of patients whom she has seen in hospital once they have returned home, as outlined above. However, in some cases she will refer them to their local community smoking cessation service. Some patients will directly request this referral because they have used the service during a previous attempt to quit, or are familiar with them through family or friends. A referral to community services is normally made by telephone or email by the adviser, who provides the contact details for the patient. She also provides the patient with the contact details of the community service. However, because many of the patients who go to the CTC undergo surgery that requires a significant recovery period, attendance at community-based smoking cessation services may not be an option. It is primarily for this reason that the specialist adviser follows up a high proportion of patients herself, either in person or by telephone.

4.5.7 Monitoring
The adviser has kept records of patients treated since 1994. She provides the hospital with patient numbers (in terms of referrals, those that set a quit date and cessation outcomes at 4 weeks) on a monthly and quarterly basis. She also provides figures for other individuals treated, such as staff members and visitors. In addition, she provides local PCT smoking cessation services with patient monitoring data and 4-week quit rates. At the time of the study, 4-week quit rates were in the range 70–75%. However, the adviser’s capacity to conduct any detailed analysis of patient numbers, patient characteristics or outcomes, including longer-term outcomes, has been significantly affected by lack of administrative support.

4.5.8 Future developments
Demand for the service provided by the CTC
smoking cessation adviser has risen over time. At the time of the study it was apparent that additional support, in particular administrative support, was required if the adviser was to be able to respond to this increased demand. However, it was not clear whether this support would be forthcoming. One interviewee suggested that the trust felt that smoking cessation services should perhaps be paid for by community-based smoking cessation services in the future, rather than by the hospital, mirroring more recent developments in other parts of the country. However, making this change would mean unravelling an established model of service that is widely used by hospital staff and patients and which has valuable lessons for developing services elsewhere.

4.6 Case 6: The Royal London Hospital
The Royal London Hospital is located in Whitechapel, in the east end of London. Patients at the Royal London Hospital and three other hospitals that form part of Barts and the London NHS Trust (St Bartholomew’s, Mile End and the London Chest Hospital) can access smoking cessation support from a specialist adviser who is part of the Tower Hamlets PCT Stop Smoking Service. The service is slightly unusual in that it is based within a specialist Smokers Clinic with an established reputation. It is staffed by a team of five trained psychologists, and not only is it the main base for the PCT Stop Smoking Service, but also it sits within Barts and the London School of Medicine and Dentistry, which is part of Queen Mary, University of London.

4.6.1 Service development
Support to help inpatients to stop smoking has been provided at the Royal London Hospital for a number of years. A formal service delivered through the Smokers Clinic was initiated in 2001, shortly after the establishment of the local NHS Stop Smoking Service. This service was gradually extended to cover the other three hospitals, although the vast majority of referrals still come from the Royal London, which is located adjacent to the Smokers Clinic. The service is provided by one adviser who has the job title of Research Health Psychologist, specialising in inpatient and pregnancy smoking cessation. However, to date the pregnancy work has taken up a very small proportion of her time, and her main responsibilities involve delivering a service to patients in hospital and arranging follow-up cessation support after discharge.

4.6.2 Management and staffing
The current post-holder is a health psychologist with Masters level training. She is employed full-time by Tower Hamlets PCT Stop Smoking Service. Her clinical work is also supervised and supported by the director of the Smokers Clinic. When the adviser is absent, patients can be seen by one of the community advisers, also based in the clinic.

4.6.3 Targeting
Cessation support can be accessed by patients in all departments across the four hospitals. However, in practice the highest number of referrals come from respiratory wards at the Royal London and, to a lesser extent, from the cardiac rehabilitation team within the London Chest Hospital, where relationships with staff are well established and referral pathways are well developed.

4.6.4 Referral within the hospital
Referral pathways have been developed by the service over a number of years. The service is promoted to hospital staff by a variety of means, including posters displayed in staff areas and on the wards and stating the extension number of the specialist, her email address and details of what the service can offer. The specialist also regularly advertises on the hospital Intranet, and has produced flyers that have been left in the pigeonholes of all clinical staff. As part of staff training
provision in the hospitals, the Stop Smoking Service has also run short awareness-raising sessions about the secondary care service, as well as improving general awareness of community services and the availability of smoking cessation support for staff.

The secondary care specialist receives on average 7 to 10 referrals per week, although this figure varies, and she can sometimes receive 3 or 4 new referrals per day.

Referrals are made directly to the specialist’s telephone extension. The majority of referrals are made directly to the specialist’s telephone extension.

Once a referral has been received, the adviser will go to the ward where the patient is located. In most instances, patients are in hospital for a week or less, and in these cases the specialist will only see them once. She will ask about the patient’s smoking behaviour and previous attempts to quit, provide verbal information and support, discuss NRT, and explain the options for continuing treatment after discharge. Patients who are in hospital for longer may have more than one session with the specialist.

4.6.5 Provision of pharmacotherapies
Making pharmacotherapy widely available to patients was a priority for the service when it was first set up, and the specialist reported that well-established procedures for prescribing were in place. NRT is on the formulary in all four hospitals, and is also available as part of ward supplies. Neither bupropion nor varenicline were prescribed to inpatients seen by the specialist at the time of the study, but they can be prescribed after discharge through the Smokers Clinic. NRT is prescribed by medical staff both as part of an attempt to quit and also for patients who are experiencing nicotine withdrawal symptoms.

Patients who have been seen by the specialist adviser are prescribed NRT by their medical staff for use while in hospital, and they are given a supply to take home after discharge. In most cases this is 1 week’s supply, although in some cases a prescription for 2 weeks can be issued.

4.6.6 Referral to the community
The Royal London service has the advantage of being delivered by an adviser who is employed by the local PCT stop smoking team. This removes some of the barriers to referral once the patient has returned home. The adviser is able to provide patients with a follow-up appointment in the community before they leave hospital, or if they have already gone home by the time the initial referral is received, a telephone call offering a specific appointment can be made. Almost all follow-ups are provided on a one-to-one basis. The community service does run group sessions and these are offered to patients, but very few choose to attend them. A drop-in clinic within the outpatients department of St Barts is also available, and is used by some patients.

In around 20% of cases it is most appropriate for the patient to have at least the first post-discharge visit in their own home. In these instances it is often the secondary care specialist who makes the visit. Most patients who are followed up in the community receive between six and seven additional weekly treatment sessions, either with the specialist herself or with another member of the clinic staff. In some cases, support may be offered over a slightly longer period.

The only complication of hospital-to-community referrals is that 30–40% of patients live outwith the Tower Hamlets PCT boundary, in other parts of London or in Essex. For example, the London Chest Hospital treats patients from all boroughs of
London. In these instances the adviser will telephone the other PCTs to provide them with patient contact details and discharge dates. She will also write to the patient at home, telling them that their details have been passed to their local Stop Smoking Service, providing contact details for that service, and also offering them the option of returning to the Smokers Clinic and seeing her again if that is what they would prefer. The specialist does not have any formal method of tracking whether clients who live in other PCT areas are always followed up once they return home.

4.6.7 Monitoring
The specialist adviser collects data from all the patients whom she sees at hospital or in the community, using a patient questionnaire developed by the Smokers Clinic. This includes the Minimum Data Set fields required by the Department of Health. The adviser is responsible for collating her own monitoring returns and submitting them to the service administrator to be included in the Tower Hamlets PCT data-monitoring returns. She retains her own data on an SPSS spreadsheet, but at the time of the study she had not had an opportunity to conduct any detailed analysis of the data or to produce any reports, and the service had not been formally evaluated in any way.

4.6.8 Future developments
The intention is to continue to develop the service for inpatients in the future. Operating across the four hospitals is a challenge, and the specialist acknowledged that if the number of referrals increases, more staff input will be required. At the time of the study an additional appointment had just been made of a full-time adviser to work with patients with mental health problems, and to provide a more intensive inpatient service at the London Chest Hospital and Mile End Hospital.
5. Conclusions

The study addresses four key questions:

1. What is the current level of service provision for smoking cessation in Scottish hospitals?
2. How does current practice compare with the Scottish guidelines for cessation support in secondary care?
3. What service models appear to be most effective?
4. What factors are important to guiding service delivery?

5.1 Current level of service provision in Scottish hospitals

The study identified 33 hospitals, mainly acute ones, in 12 of the Scottish health board areas that were providing or developing dedicated smoking cessation support. Hospitals in smaller rural health board areas appear to be less active, as resource constraints limit their ability to specialise. The intensity of support provided also varies between hospitals. In most instances services are delivered by specialist smoking cessation advisers who support and take referrals from frontline nursing and medical staff, and who operate either from a permanent hospital base or from a base in the community. In two hospitals the service is led by respiratory nurse specialists with additional training in smoking cessation, who have a proportion of their time allocated to cessation work. The majority of hospital services refer patients who wish for continued support on discharge to specialist community-based services. In many instances these are elements of the same service. In some smaller rural health board areas the same adviser may continue to see the patient after discharge. In one area where the specialist community service is not equipped to take referrals, the hospital service offers continued support by telephone. Attrition rates between discharge and being picked up by community services are frequently described as high.

Most of the hospitals that provide dedicated support are covered by one part-time or full-time specialist adviser, although in some instances support is provided remotely either from another hospital or from the community. Most services report that staff resources are stretched, in some instances severely so, with many operating without any dedicated administrative support. This often means that the goal of offering a hospital-wide cessation service is compromised. These findings indicate that a significant proportion of patients in Scottish hospitals have no access to on-site specialist cessation support, and where such support is available it tends to be focused on specific departments, typically respiratory and cardiology departments, and inpatient acute services. Staff in these areas are more likely to identify a need for cessation support, and are more willing to work with specialist advisers.

5.2 Adherence to the current Scottish guidelines

The guidelines suggest that specific NHS patient populations, including inpatients, should be routinely offered structured behavioural support and medication while in hospital, and continued support by smoking cessation services after discharge (NHS Health Scotland/ASH Scotland, 2004). The study findings indicate that although some hospitals aspire to provide patients with access to specialist behavioural and pharmacological support, in practice hospital support is often limited to certain areas. Many other hospitals would appear not to have any form of specialised cessation support available to patients. A recent update to the Scottish guidelines (NHS Health Scotland/ASH Scotland, 2007) emphasises that hospital clinicians and nurses should be encouraged to access accredited training in brief advice, refer people who smoke to intensive smoking cessation services and, if appropriate, offer patients a prescription for pharmacotherapy. The study findings indicate that, in those hospitals where dedicated smoking cessation advice is available, clinical and nursing staff do have access to training in brief advice, but that in many instances resource constraints and the need for staff to attend mandatory training courses
mean that many are unable to take advantage of this training. The low uptake of brief advice training has a limiting effect on the numbers of patients referred to smoking cessation services in the community and to specialist hospital cessation services, where these exist. The majority of hospitals with a dedicated smoking cessation service do provide patients who are attempting to quit with a supply of or prescription for pharmacotherapy on discharge. The situation in hospitals without dedicated cessation support is unclear.

5.3 Service models that show promise
Findings indicate that the support of a dedicated specialist working from within or in close proximity to the hospital is a prerequisite for any successful service. A number of services in Scotland employ this approach, as do two well-developed case studies in England that were examined as part of this study. The effectiveness of services that rely upon frontline staff to provide brief advice and referral to the community is extremely limited, insofar as they generate only small numbers of referrals.

Two main models of provision of dedicated support were identified, namely a hospital-led service model with ongoing cessation support provided from the hospital service after discharge, and an integrated service model with specialist cessation services in the hospital and community working together to an agreed joint service protocol. Currently most specialist services are based on variants of the latter model.

5.4 Factors that are important to guiding service delivery
The findings reveal a number of useful learning points for the development and delivery of cessation support in secondary care, which could form a basis for agreeing a set of quality standards. These are broken down according to the following study themes: service development; management and staffing; referral within the hospital; provision of pharmacotherapies; referral to the community; training; and monitoring. Given the current emphasis on integrated service models, many of the learning points to emerge relate to this mode of operation.

Service development
1. Smoking cessation services in secondary care should be available to all patient groups via all departments and patient services, with staff resources sufficient to meet demand.

2. Close consultation with hospital management and senior clinical staff at the service development stage is important for securing support and access to patients and frontline staff, and for ensuring that the service becomes embedded into everyday practice.

3. Establishing locally agreed referral pathways and procedures both within the hospital setting and with community cessation services is important for building strong partnerships and support for the service.

4. For services that cover a number of hospital sites, development of clearly documented referral procedures is important for ensuring equity of support across sites, and for enabling advisers to move between hospitals to provide cover.

Management and staffing
5. Specialist advisers with protected time dedicated to building referral networks and to providing cessation support are important for establishing a viable service.

6. Services should be equipped to provide year-round support, and should have alternative staffing arrangements in place to provide cover during staff absence. Services that are dependent on one cessation adviser are particularly vulnerable to problems and delays when this person is unavailable.

7. Secondary care advisers should be based within or in close proximity to the hospital site where they deliver cessation support. Remote
working leads to inefficient use of advisers’ time, limits their ability to respond to patients whose stay in hospital is short, and makes it difficult for the service to establish the necessary presence to cultivate referrals. It can also result in inequalities of access to cessation support, where support is provided remotely from one hospital to support another.

**Referral within the hospital**

8. Initial attendance is a key time for referral, as early intervention reduces the likelihood of prospective clients slipping through the net. Particular attention is needed to ensure that clinical and nursing staff responsible for assessment on or prior to admission are delivering brief advice and referring those who wish to stop smoking to a specialist adviser.

9. Secondary care cessation services should employ internal referral methods as the primary means of identifying clients. Relying on direct access methods, such as ‘walking the wards’ and consulting with duty nursing staff, limits the service’s ability to reach all departments and patient services, and can result in inequities of access, particularly in larger hospitals.

10. Investment in time and effort is needed, particularly during the early stages of development, to build and establish internal referral networks. Identifying service advocates such as ‘link nurses’ in key departments, and undertaking informal staff briefing sessions ‘on the ward’ can be effective strategies for cultivating referrals.

11. Referral pathways need to be established with staff from all wards and patient services, not just with those departments that are receptive to the idea of offering brief advice.

12. A range of methods can be employed, but referral by email, telephone or pager may be preferable to paper transfer of patient details, as these methods are quicker and more straightforward.

13. The contact telephone number for the hospital cessation service needs to be widely publicised in both public spaces and patient consultation rooms.

14. Patients who are referred for elective surgery should have access to specialist support to help them to stop smoking before they are admitted.

**Provision of pharmacotherapies**

15. Pharmacological support should be made available not only as part of an attempt to quit, but also to assist with acute withdrawal symptoms. There is some anecdotal evidence that pharmacotherapies which are initially prescribed to support temporary abstinence can lead to a genuine attempt to quit.

16. Stocks of pharmacotherapies should be maintained not only in the hospital pharmacy, but also at the point of need on the wards and in patient clinics.

17. Patients who are motivated to stop smoking and who initiate an attempt to quit while in hospital should be provided with a supply of or prescription or voucher for pharmacological support on discharge. Evidence suggests that a 2-week prescription may be preferable to one for a shorter period, in order to minimise the risk of supplies running out before the patient can access support in the community. Systems should also be established for patients to continue to receive pharmacological support within the community setting.

**Referral to the community**

18. Hospital cessation services that are not set up to provide ongoing support after discharge need to work closely with services that provide cessation support in the community. In some instances it may be feasible and more appropriate for the secondary care adviser to be employed by the community service, but based within the hospital.
19. The more quickly patients are picked up by community services, the more likely they are to sustain their attempt to quit. Anecdotal evidence suggests that follow-up of patients by the same adviser who provides support in the hospital can also help to reduce drop-out rates. Services that operate an appointment system should aim to arrange the patient’s first post-discharge appointment before they leave hospital.

20. Special provisions should be made for patients who are housebound to be supported in the community by telephone and/or home visits.

Training
21. Brief advice training enhances the ability of staff to raise the issue of smoking, and encourages patient referrals. More resources are needed to provide protected time for hospital-based staff to attend training courses on brief advice. There is also a need to make this type of training mandatory if the health benefits of smoking cessation are to be maximised for hospital patients.

22. Offering brief advice training courses on the hospital site can improve attendance and provides hospital-based advisers with an opportunity to build stronger links with frontline staff and to brief staff on referral pathways and procedure.

Monitoring
23. Systems should be established to ensure accurate recording of smoking status, referral, support and outcome. Completion of the National Minimum Data Set needs to be enforced.

24. Secondary care services need access to dedicated administrative support to permit accurate record keeping and monitoring. Relying on advisers to perform this role is an inefficient use of resources.

25. Services need to ensure that appropriate consent procedures are used for patients who are making a supported attempt to quit, in order to facilitate data sharing and follow-up by community cessation services.

26. Feedback to hospital-based advisers on the outcome of referrals should be available. When a patient is referred, the hospital adviser should be able to access information to determine if and when they have been seen since discharge, for how long and what outcomes were achieved, if they are not conducting this follow-up themselves. Advisers should be equipped to feed back this information to the hospital staff responsible for making referrals, and to comment on the staff contribution to quit rates achieved.

27. National and local monitoring systems need to incorporate a field for referral source so that outcomes for hospital referrals can be analysed separately. In larger hospitals, establishing a system for monitoring referral sources at departmental and ward level provides a systematic means of identifying and targeting areas of low activity.

Finally, further research is needed to examine the relationship between different models of smoking cessation support and cessation outcomes in Scotland, and to compare existing data on cessation outcomes for hospital referrals with those for patients referred to specialist community services from other settings. This study has also identified a number of promising examples of practice that could form the focus of more detailed evaluation.
6. References


Appendices
## Appendix 1. Case study service leads

| Case 1: Dumfries and Galloway Royal Infirmary | Trish Grierson  
Service Coordinator  
Smoking Matters  
NHS Dumfries and Galloway  
Garden Hill Primary Care Centre  
2 Garden Hill Road  
Castle Douglas DG7 3EE | Tel: 0845 602 6861  
Email: trish.grierson@nhs.net |
|-----------------------------------------------|-----------------------------------------------------|
| Case 2: Falkirk and District Royal Infirmary | Gillian Bruce  
Lead Smoking Cessation Nurse  
Specialist  
Acute Services  
Smoking Cessation Service  
NHS Forth Valley  
Falkirk and District Royal Infirmary  
Hut 5  
Majors Loan  
Falkirk FK1 5QE | Tel: 01324 678575  
Email: gillian.bruce2@nhs.net |
| Case 3: NHS Greater Glasgow and Clyde Smoking Cessation Service – Glasgow Royal Infirmary | Shirley Hamilton  
SHPO Tobacco, Acute and Maternity Services  
Smoking Concerns  
Health Improvement Acute Planning  
2 West, Dalian House  
350 St Vincent Street  
Glasgow G3 8YZ | Tel: 0141 201 4992  
Email: shirley.hamilton@ggc.scot.nhs.uk |
| Case 4: Wishaw General Hospital | Jean Girvan  
Smoking Cessation Specialist Nurse  
Ward 6 – Admin Corridor  
Wishaw General Hospital  
Lanarkshire NHS – Acute Services Division  
50 Netherton Street  
Wishaw ML2 0DP | Tel: 01698 366466  
Email: jean.girvan@lanarkshire.scot.nhs.uk |
| Case 5: The Liverpool Cardiothoracic Centre | Trish Jones  
Smoking Cessation Adviser  
Liverpool Cardiothoracic Centre NHS Trust  
Thomas Drive  
Liverpool L14 3PE | Tel: 0151 228 1616  
Email: Trish.Jones@ctc.nhs.uk |
| Case 6: The Royal London Hospital | Katie Myers  
Research Health Psychologist  
Smokers Clinic  
Royal London Hospital  
55 Philpot Street  
London E1 2JH | Tel: 0207 882 8230  
Email: k.myers@qmul.ac.uk |
Appendix 2. Inpatient stop smoking care pathway (Greater Glasgow)

Stop Smoking Care Pathway

1. Identify smoking status and record date of last cigarette smoked
2. Brief education provided on the effects of smoking on health and the benefits of stopping smoking
3. Assess motivation to stop smoking

Is The Patient Motivated To Stop Smoking?

**YES**
Patient requests help and is motivated to stop

Contact Hospital
Smoking Cessation Service
North (2) 0729
South (6) 5148

Patient seen by Smoking Cessation Adviser. Assessment carried out and NRT prescribed.

* First choice 16-hour patch – prescribe for 2 weeks and review daily. Smoking Cessation Adviser to provide intensive support for duration of hospital stay.

On discharge:
Patient receives 2 weeks of NRT. Smoking Cessation Adviser refers to CHP for further intensive support and monitoring. Adviser refers to the Starting Fresh pharmacy service for follow-up NRT – document in case notes.

Prescription discharge letter † GP

4-week follow-up conducted in primary care
12-week and 12-month follow-up by secondary care service

**No**

Not motivated to stop at present:
- Patient informed of support available
- Designated hospital leaflet and contact numbers given for future use in hospital/primary care
- Document in case notes

Patient experiencing withdrawal symptoms on ward:
- Start treatment
- Document when last cigarette was smoked
- ASSESS and commence on 16-hour patch to relieve withdrawal symptoms for length of hospital stay
- Review daily

Discontinue on Discharge unless wishing to continue with quit attempt – then inform Hospital Smoking Cessation Adviser

NB Patients admitted who are making quit attempt – arrange support and refer to Smoking Cessation Adviser and ensure...
Hospital Inpatient Smoking Policy

Prompt Card for Staff

Ask the following as part of routine admission:
  • Do you smoke? Document answer in notes.

If answer is yes, ask the following:
  • How many do you smoke each day?
  • Have you tried to stop smoking?
  • Are you aware of the risks of smoking and the benefits of stopping?
  • Give simple, clear advice on stopping.
  • Allow informed choice.

Advise the patient to stop smoking.

Ask: Would you like to stop smoking now?
If the answer is yes, refer the patient to hospital Stop Smoking Service.
  • Level 3 – Motivated to stop

South Hospitals Tel 65148
North Hospitals Tel 20729

If the answer is no, offer information on support while the patient is in hospital.
  • Level 2 – Acute nicotine withdrawal/unable to smoke.

Commence NRT 16-hour (15 mg) patch
(discontinue on discharge)
Appendix 3. NRT patient assessment protocol
(Greater Glasgow)

Nicotine Replacement Therapy (NRT)
Patient Assessment Form

Is the patient motivated to quit in the next two weeks?

YES

Are there any exceptional circumstances?

- Age < 18 years
- Recent cardiac event (stroke, MI, unstable angina, cardiac arrhythmia, coronary artery bypass graft or angioplasty
- Peptic ulcer (no oral products)
- Pregnant/breastfeeding

No

Discuss products and recommend patients choice

Pregnant women referred

Breathe Project

- NRT can be recommended for use in patients with cardiovascular disease, with the agreement of the patient’s physician, even if the disease is acute or poorly controlled
- NRT may aid smoking cessation in adolescent smokers
- Use of NRT by pregnant smokers may benefit the mother and foetus if it leads to cessation of smoking. If NRT is used, advise that it be stopped if the mother resumes smoking
- Avoid oral products in patients with active peptic ulcer disease

YES

- Contact patient’s senior medical staff to obtain signed consent below.
- Discuss products and ensure patient’s choice is prescribed.

Patient’s Name ___________________________ Date of Birth ___________________________
Hospital Number ___________________________ Ward Number ___________________________
Senior Medical Staff Name __________________ Signature ____________________________
NICE guidance: relevance for smoking cessation in secondary care in Scotland

On 27 February 2008, the National Institute for Health and Clinical Excellence (NICE) in England published its public health programme guidance on “smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities.”¹ One of the recommendations in this guidance relates directly to the provision of smoking cessation support for hospital patients (Recommendation 6). A second recommendation relates to smoking cessation training for health professionals, including those in secondary care (Recommendation 12). This short note describes the relevant parts of the guidance and assesses the extent to which current services in Scotland, as described in this mapping report, conform to the recommendations. This guidance does not apply in Scotland, but NHS Health Scotland will be producing a commentary on the guidance with reference to the Scottish context.

Recommendation 6 of the NICE guidance: Specific groups

Elements of Recommendation 6 relate directly to smoking cessation for hospital patient. These are listed in Box 1.

Box 1: Recommendation 6

Who is the target population?
People receiving care and advice from a health professional in primary care or in hospital.

Who should take action?
Who is the target population?
People receiving care and advice from a health professional in primary care or in hospital.

Who should take action?
• PCTs and acute trusts.
• Healthcare professionals.

What action should they take?
• Healthcare professionals should be trained to give brief advice on stopping tobacco use, and should have contact with the local NHS Stop Smoking Service, to which they can refer people.
• Healthcare professionals should identify and record the smoking and/or tobacco use status of all their patients. Those who use tobacco should be:
  – reminded at every suitable opportunity of the health benefits of stopping
  – offered brief advice and, if they want to stop using tobacco, referred to the local NHS Stop Smoking Service. If patients do not wish to attend the service, they should be offered brief advice and support to help them quit, and pharmacotherapy as appropriate.

A number of elements of Recommendation 6 relate directly to provision in secondary care. The key elements include:

- identification of smoking status
- provision of brief advice
- pre-operative smoking cessation
- behavioural support and NRT while in hospital
- referral and appointment with community cessation services.

**Identification of smoking status**

The NICE recommendations state that healthcare professionals should identify and record the smoking and/or tobacco use status of all their patients. This includes those in secondary care. Findings from this mapping study suggest that, in the 28 Scottish hospitals where specialist smoking cessation support was available at the time of the study, all services asked patients about their smoking and whether they wished for help to quit, and discussed ways of making an attempt to quit, including referral to a smoking cessation specialist either in the hospital or after discharge. However, for those hospitals where no dedicated smoking cessation support was available at the time of the study, it is not clear to what extent smoking status was routinely identified. Similarly, resource constraints in those hospitals where specialist support was available meant that cessation advisers could not always reach all patient services and departments. Instead, many worked more closely with those hospital staff who were most receptive to the idea of providing access to specialist support.

**Provision of brief advice**

The NICE recommendations state that patients who use tobacco should be offered brief advice. This study found that brief advice is delivered to all patients in hospitals where specialist cessation support is available. It was not possible to ascertain the extent to which brief advice is given to patients in hospitals without this support. It is likely that the delivery of brief advice is variable. The NICE guidance also specifies that health professionals who give brief advice should have ‘contact with the local NHS Stop Smoking Service to which they can refer people.’ The study found that in those hospitals where specialist cessation support was provided, links with community-based cessation services were...
well developed. However, these links were significantly weaker or non-existent in those areas of secondary care where specialist support was not available. Clearly more needs to be done to ensure that all patients attending hospital in Scotland have their smoking status identified, receive brief advice, have access to specialist support in hospital, and have the option of referral to community services.

**Pre-operative smoking cessation**

The NICE guidance also specifies that patients referred for elective surgery should be encouraged to stop smoking before their operation. Our mapping study found little evidence that this happens routinely. It may be that patients’ GPs are providing them with brief advice and a prescription for appropriate pharmacotherapy (and in some cases, referral to community-based cessation services) pre-operatively, but assessment of the extent of this was beyond the scope of the study. One of the English case studies included in this report, the Liverpool Cardiothoracic Centre, had an established system for pre-operative smoking cessation where clients attended an outpatients department for a pre-operative assessment and were provided with advice, access to NRT and follow-up from there. One of the Scottish case studies was in the process of piloting a scheme for offering cessation support to pre-operative patients, with pre-operative nursing staff providing brief advice and referral to generic cessation services. In another, pre-assessment nurses were trained to provide brief advice and to refer patients to the local specialist smoking cessation service.

**Behavioural support and NRT while in hospital**

Once patients are in hospital, the guidance specifies that they should be offered advice and NRT from a trained adviser. The mapping study found that in 28 Scottish hospitals, this type of provision was delivered by 12 full-time and 14 part-time specialist advisers. Five further hospitals were in the process of developing specialist cessation services at the time of the study. The type of support and number of consultations offered varied, but most services offered one or two counselling sessions while the patient was in hospital, depending on length of stay. The first meeting with an adviser usually lasted between 30 and 60 minutes, with follow-up visits usually lasting between 15 and 20 minutes. As well as providing behavioural support, advisers were able to directly prescribe, or work with other health professionals to prescribe, NRT or other pharmacological cessation aids. Most hospitals provided NRT either to support an attempt to quit, or as a temporary abstinence measure to help the patient to cope with nicotine withdrawal symptoms while confined in hospital.

**Referral and appointment with community cessation services**

Referral pathways with community-based smoking cessation services were in place in all hospitals that had specialist support. In some cases the hospital-based staff were employed by or were part of the community service, which greatly facilitated referral and follow-up. In some rural areas support was provided by the same adviser in hospital and in the community. Two services also provided follow-up telephone support for hospital patients. Rapid referral was considered important, and all services aimed for this, although in practice it was not always easy to achieve. In many instances it was not possible to arrange a first appointment before discharge. However, many services had in place a strict policy of following up patients immediately upon discharge to arrange an appointment, typically within 2 or 3 days. In all services, prescriptions or supplies of NRT were also provided to patients at the time of discharge, and in some areas a 1-week supply while in others a 2-week supply was prescribed.

**Recommendation 12 of the NICE guidance: Training**

Elements of Recommendation 12 relate to smoking cessation for hospital patients. These are italicised in Box 2 (opposite).
A number of elements of Recommendation 12 relate directly to training provision in secondary care. The key elements include:

- training in brief advice and referral
- training for postgraduates and undergraduates
- specialist training.

Training in brief advice and referral

The NICE recommendations state that training should be provided to ‘all frontline healthcare staff to offer brief advice’ and where possible ‘to make referrals.’ In total, 27 of the 28 hospitals identified as providing specialist cessation support offered regular training in brief advice to a broad range of frontline staff. However, the number of hospital staff that take up this offer was described as low. Key barriers that were identified included difficulty in facilitating staff release, and competition with other areas where training is mandatory. In most instances the ‘training’ that was provided tended not to be within current guidelines for ‘brief advice’, and was more appropriately described as ‘awareness-raising sessions’ designed to inform staff of referral protocols. Although these sessions were of limited duration, they were found to enhance staff confidence in raising the issue of smoking and quitting with patients, and to increase the number of internal referrals. Specialist services did not require frontline hospital staff to make patient referrals to NHS Stop Smoking Services in the community, as this approach was found to be ineffective. Instead the referrals were made to specialist advisers based within the hospital. Study limitations meant that it was not possible to ascertain the extent to which brief advice training is offered and taken up in those hospitals that do not have specialist cessation support.
Training for postgraduates and undergraduates
The NICE recommendations state that measures should be undertaken to ensure that training in how to support people to quit smoking is part of the core curriculum for healthcare undergraduates and postgraduates. Evidence from this study indicates that this type of training is not a common feature at these levels in Scotland, and that there is broad support among healthcare workers for this type of training to be made mandatory.

Specialist training
The NICE recommendations state that actions should be taken to provide additional, specialised training for those working with people who are hospitalised. All cessation advisers working in the hospital setting in Scotland had received specialist training prior to coming into post, and most also receive regular training updates. For most, this training was in addition to qualifications and experience as healthcare or community workers.

Overall, where specialist services for hospital patients exist in Scotland, they appear to comply with the relevant guidance produced by NICE. Therefore it is not so much the content or structure of services that is the issue, but the fact that a significant proportion of smokers entering hospitals in Scotland still do not have access to the type of support to stop smoking that is advocated by NICE. Even in those hospitals with established services, these are not available on all wards or to all patients, due to staffing, resource and time constraints. Therefore the challenge for the future is to develop more extensive and comprehensive smoking cessation services for hospital patients in Scotland.