About these guidelines

These guidelines have been written in parallel with guidance on the cost effectiveness of smoking cessation interventions, produced by the Centre for Health Economics at the University of York. The cost effectiveness guidance underpins these clinical guidelines and provides the economic justification for them. It is published as the second part of this *Thorax* supplement. These smoking cessation clinical guidelines are also published in a shorter version as a journal article (*BMJ* 1999;**318**: in press).

The clinical guidelines have been submitted to many professions for their official endorsement and support. This was not a passive process and their suggestions are reflected in this final version.

The guidelines were commissioned by the Health Education Authority (HEA), which is responsible for health education in England. They are written for the English health care system but may prove relevant and adaptable to other countries and health care systems.

Comments and questions about these guidelines can be addressed to Dr Ann McNeill at Health Education Authority, Trevelyan House, 30 Great Peter Street, London SW1P 2HW.

Professional endorsement

At the time of going to press the following organisations have endorsed these guidelines: Royal College of Physicians (London), Royal College of General Practitioners, British Medical Association, Royal College of Nursing, Royal College of Midwives, Community Practitioners' and Health Visitors' Association, British Thoracic Society, British Lung Foundation, National Asthma Campaign, National Primary Care Facilitators Programme, National Heart Forum, British Dental Association, British Dental Hygienists Association, National Pharmaceutical Association, Royal Pharmaceutical Society of Great Britain, Action on Smoking and Health, ASH Scotland, Quit, Association for Public Health, Imperial Cancer Research Fund, Cancer Research Campaign.

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Recommendations

These recommendations form a blueprint for tackling the problem of smoking within the National Health Service (NHS). They are being assessed for incorporation within future national arrangements for quality and effectiveness by the National Health Service Executive (NHSE). The rationale and supporting evidence for each recommendation is explained in the text. After each recommendation the page number is given where it can be found.

Recommendations for the primary care team

1 Assess the smoking status of patients at every opportunity; advise all smokers to stop; assist those interested in doing so; offer follow up; refer to specialist cessation service if necessary (page S8).
2 Recommend smokers who want to stop to use nicotine replacement therapy (NRT) and provide accurate information and advice on NRT (page S8).

Recommendations for all health professionals

3 Assess the smoking status of patients at every opportunity; advise all smokers to stop; assist those interested in doing so; refer to specialist cessation service if necessary; recommend smokers who want to stop to use NRT; provide accurate information and advice on NRT (page S9).

Recommendations for smoking cessation specialists

4 Intensive smoking cessation support should where possible be conducted in groups, include coping skills training and social support, and should offer around five sessions of about one hour over about one month, and follow up (page S10).
5 Intensive smoking cessation support should include the offer of or encouragement to use NRT, and clear advice and instruction on how to use it (page S10).

Nicotine replacement therapy

6 Smokers should be encouraged to use NRT as a cessation aid. It is effective and safe if used correctly (page S11).
7 Health professionals who deliver smoking cessation interventions should give smokers accurate information and advice on NRT (page S11).

Other populations and topics

8 Hospital staff should assess the smoking status of patients on admission, advise smokers to stop, and assist those interested in doing so. Patients should be advised of the hospital's smoke free status before admission (page S13).
9 Hospital patients who smoke should be offered help in stopping smoking, including the provision of NRT (page S13).
10 Pregnant smokers should be given firm and clear advice to stop smoking throughout pregnancy, and given assistance when it is requested (page S13).
11 Cessation interventions shown to be effective with adults should be considered for use with young people, with the content modified as necessary (page S13).
12 Consideration should be given to ways of increasing the availability of NRT to low income smokers, including at a reduced cost or free of charge (page S14).
13 Smoking and smoking cessation should be part of the core curriculum of the basic training of all health professionals (page S15).
14 Training should be a core part of a smoking cessation programme in all health authorities. Protected time and funding should be built into this programme (page S15).

Recommendations for health commissioners

15 To produce cost effective significant health gain in the population, smoking cessation interventions should be commissioned (page S16).
16 Review current practice, identify needs, and provide core funding to integrate smoking cessation into health services; plan a cessation strategy with public health specialists; seek advice from smoking cessation specialists (page S16).
17 These plans should include a specialist cessation service (page S16).
18 Core fund smoking cessation training, or make sure that smoking cessation is prioritised within existing training budgets (page S17).
19 Make provision to ensure that NRT is available to hospital patients who need it, in conjunction with professional advice and cessation support (page S17).
20 Require all services, departments, and clinics to introduce systems to maintain an up to date record of the smoking status of all patients in their (paper or electronic) notes. It should be regarded as a vital sign (page S17).
21 Ensure that all health care premises and their immediate surrounds are smoke free (page S17).
22 Work with clinicians to put systems in place to audit smoking cessation interventions throughout the health care system (page S17).

1 Introduction

Each year in the UK smoking causes more than 120 000 deaths of people aged 35 or more, 20% of deaths at all ages, and more than 25% of deaths between 35 and 65. Smoking is reducing the female advantage in life expectancy and widening the social class divide in mortality,[1] and it remains the largest single preventable cause of death and disability in the UK.

A range of tobacco control measures, including taxation and price policy, advertising restrictions, public information and health promotion, and cessation support are effective in reducing tobacco use.[2 3] These guidelines outline what the National Health Service (NHS) can contribute to a national smoking cessation strategy.

Purpose of these guidelines

The purpose of these guidelines is to recommend effective interventions to encourage and help smokers stop, to make the case for allocation of funds to smoking cessation, and to propose the integration of smoking cessation interventions into routine clinical care throughout the health care system. They are for health commissioners, managers and clinicians. The recommendations are based on published research. They are accompanied (in the second part of this supplement) by guidance for commissioners on the cost effectiveness of smoking cessation.

Structure

The development of the guidelines and the evidence base for the recommendations are explained in this introductory section. In the following sections the recommendations are presented by target audience, with additional sections on nicotine replacement therapy (NRT) and other populations and topics. The sections are:

1 Introduction.
2 Recommendations for the primary care team.
3 Recommendations for all health professionals.
4 Recommendations for smoking cessation specialists.
5 Nicotine replacement therapy.
6 Other populations and topics.
7 Recommendations for health commissioners.

Section 6, "Other populations and topics", includes hospital patients, pregnant smokers, young people, low income smokers, sex, weight gain, other treatments, No Smoking Day, telephone help lines, training. NRT is dealt with in a separate section to avoid repetition because it is applicable to all target groups.

To keep the recommendations succinct and the style accessible, we have where possible left qualifying statements as implied, or put them in the main text. For example, the recommendation that *hospital patients who smoke should be offered help in stopping smoking* excludes some patients such as lung cancer sufferers entering terminal care, thus the phrase *wherever appropriate* is implied.

Scientific basis and review process

These guidelines are based on systematic reviews conducted by the Cochrane Tobacco Addiction Review Group[4–14] in the UK (hereafter referred to as the Cochrane Library reviews), and by the Agency for Health Care Policy and Research (AHCPR)[15] in the USA, part of the US Public Health Service. They also draw on the American Psychiatric Association (APA) guideline (1996).[16] Each Cochrane Library review presents the evidence, results and conclusions for a particular treatment, but does not make clinical or policy recommendations. The Cochrane Library abstracts are available free online at *www.cochrane.co.uk*. Subscription information can be obtained from Update Software in Oxford, UK on 01865 513902. The AHCPR Clinical Practice Guideline on smoking cessation[15] makes recommendations on smoking cessation for three audiences: primary care clinicians, tobacco cessation specialists and programmes, and health care administrators, insurers, and purchasers.

The AHCPR guideline took several years to produce and involved around 125 people. Under their chair, Dr Michael Fiore, 18 panel members selected topics, reviewers, and the criteria for articles to be included in the review. Ten people reviewed articles and 76 peer reviewers looked at the final guideline. Computer searches identified 3000 articles which were reduced by the reviewers to 300 articles which met the panel's criteria.

The criteria were that the article:

- reported the results of a randomised controlled trial;
- provided at least five months follow up;
- was published in a peer reviewed journal between 1975 and 1994;
- was in English.

The reviewers created evidence tables from these articles which were subjected to meta-analyses (except for nicotine patch and gum for which they used meta-analyses already published). The panel reviewed the reviews, evidence tables, and meta-analyses, drew preliminary conclusions, and drafted the guideline, which was reviewed by all panel members and the 76 peer reviewers.

Our guidelines are based principally on the Cochrane Library reviews and the AHCPR guideline. They were reviewed by 19 experts, re-drafted in the light of their comments, and then submitted to professional bodies for their support and endorsement. This final version incorporates further feedback from the original reviewers, the professions, and the *Thorax* peer review process.

Keeping the guidelines up to date

The Cochrane Library reviews are updated regularly, and at the time of going to press a summary of their reviews is due to be published in a scientific journal. The AHCPR guideline was published in April 1996 using evidence published up to 1 January 1995. It is being revised at the time these guidelines went to press. It is hoped that these guidelines will be updated periodically to incorporate new evidence. This version was completed in September 1998.

Evidence base

The AHCPR guideline classified its recommendations according to the strength of evidence and we have adopted the same approach:

A Many well designed randomised controlled trials directly relevant to the recommendation, yielding a consistent pattern of findings.

B Some evidence from randomised controlled trials, but not optimal. More interpretation of the evidence was needed. For example, there were not many randomised controlled trials, their results were not consistent, they were not directly relevant to the recommendation. They may not have been directly relevant because, for example, the study population was different.

C No randomised controlled trials but the issue is important enough to merit a recommendation which is based on published evidence and expert opinion of the authors and reviewers.

These guidelines focus on smoking because the majority of tobacco users are cigarette smokers[17] so most research interventions have been with smokers. Thus we have followed the AHCPR view[15] and consider that our recommendations are relevant to all tobacco users.

In order to keep these guidelines succinct we have not reproduced all the evidence for all interventions, but have summarised the key evidence in a table. Further evidence is presented in the text when relevant. Readers who would like more detail should consult the Cochrane Library reviews[4–14] and AHCPR guideline[15] where they can also find explanations of the meta-analysis techniques used.

The systematic reviews[4–15] typically report evidence of treatment efficacy in terms of odds ratios—that is, the odds of cessation using an approach compared with the odds of cessation in some control condition. The odds ratio for no effect is 1.0. Thus, in the AHCPR guideline,[15] the odds ratio of physician advice compared with a usual care control is 1.30, meaning that smokers given advice have 30% better odds of stopping than those not advised.

The advantage of this method is that it represents the treatment effect irrespective of other factors. The problem is that clinicians, planners, and others may need to know actual cessation rates. For example, actual rates are needed to estimate cost effectiveness. But reporting actual cessation rates is also problematic. Outcomes are greatly affected by the study population. Two apparently similar studies of general practitioner (GP) advice may have different results because one study involved all smokers visiting the GP, while the other involved only smokers who agreed to participate. The latter would be likely to have more motivated smokers and thus higher cessation rates. Another factor which will influence absolute rates is the set of criteria used to determine abstinence. The AHCPR guideline[15] uses point prevalence of abstinence or continuous abstinence, depending on the study.

We have followed the AHCPR approach by reporting the *improvement* in the cessation rate over and above that in the control (the incremental cessation rate) and used the figures reported in the AHCPR guideline and the Cochrane Library reviews. They calculated cessation rates from the odds ratio. This is a robust way of showing intervention effects. However, the figures presented may look unfamiliar to some experts. This will be because of the particular studies grouped together in the comparison, and results from the way meta-analyses group sometimes disparate studies.

It must be emphasised that the evidence table only gives the effects of *individual intervention elements*. To estimate the overall effect of a particular package of treatment—for example, intensive behavioural support plus NRT—one can, broadly speaking, add together the effects of the elements. Thus, intensive support plus NRT can increase long term abstinence rates by some 16% (8% intensive support plus 8% NRT) over control.

A recent large scale study, the American Lung Health Study, showed what can be achieved with a state of the art intensive smoking treatment programme.[18] In that study the package of behavioural support and nicotine replacement increased long term (12 month) abstinence rates by some 25% over that achieved in the control group.

Evidence table

Intervention element	*Data source*	*Increase in % of smokers abstinent for 6 months or longer*
Very brief advice to stop (3 min) by clinician versus no advice	AHCPR[15]	2
Brief advice to stop (up to 10 min) by clinician versus no advice	AHCPR[15]	3
Adding NRT to brief advice versus brief advice alone or brief advice plus placebo	Cochrane[5]	6
Intensive support (e.g. smokers' clinic) versus no intervention	AHCPR[15]	8
Intensive support plus NRT versus intensive support or intensive support plus placebo	Cochrane[5]	8
Cessation advice and support for hospital patients versus no support	AHCPR[15]	5
Cessation advice and support for pregnant smokers versus usual care or no intervention	AHCPR[15]	7

Note: The given cessation rates are for the individual elements. The additive nature of some of these increases in abstinence rates is explained in the text.

A NOTE ON META-ANALYSES

Meta-analyses provide a statistical means of combining the results from two or more studies to provide a single estimate of the effectiveness of an intervention. Different studies may produce different results because of chance variations between the samples used in individual studies. Meta-analyses can, in effect, smooth over these differences to produce a more accurate estimate of the effect size, almost as though all the studies had been combined into one mega-study.

The problem with meta-analyses is that it is rare for different studies to be identical to each other in terms of design and study population. Common differences between studies in smoking cessation are: differences in populations studied (for example, excluding light smokers versus not excluding light smokers, including all smokers whether or not they express an interest in stopping smoking or only those who sign up for help with stopping smoking); differences between interventions (for example, different forms of behavioural treatment in smokers' clinics, different self-help materials, different types and amounts of "brief advice"); differences in outcome criteria (for example, whether participants were smoking at the follow up point as opposed to having to be abstinent from the time of the intervention continuously to the follow up point, different lengths of follow up).

Such differences can make the conclusions of meta-analyses misleading. It may be that a given intervention with a given study population and a rigorous outcome criterion has a large effect but, when combined with other interventions or studied in different populations, the effect is diluted. Meta-analyses often attempt to assess whether differences between effects of component studies are greater than would be expected by chance so that the overall conclusions can be tempered accordingly. However, there is no adequate statistical method of compensating for important differences in study design.

Therefore, while meta-analyses can give some indication of effectiveness of a category of interventions, some genuine effects may be masked and particular attention needs to be paid to individual studies to examine how best to deliver an intervention.

But what is important is that there **is** a significant treatment effect, and its approximate magnitude, and this is what the evidence table shows. The incremental cessation rates in the table, calculated from the odds ratios, are all statistically significant.

Why smoking cessation guidelines are timely

Smoking remains the largest preventable cause of premature death and disability in this country, and smoking related diseases cost the NHS approximately £1500 million a year in England.[19] However, effective and cost effective smoking cessation interventions are available. Smoking fits the National Health Service Executive's (NHSE) criteria for developing clinical guidelines, and new developments in health care in Britain will, it is hoped, produce a climate which encourages preventive health care and more attention to evidence based medicine.

SMOKING CESSATION IS EFFECTIVE

Smoking cessation interventions are effective,[3–5 15] as shown in the evidence table. Brief advice in primary care, more intensive interventions, NRT, and some other interventions have been investigated in randomised controlled trials which have been systematically reviewed.

SMOKING CESSATION IS COST EFFECTIVE

Smoking cessation interventions are very cost effective.[19–21] They are guaranteed to bring population health gains, for relatively modest expenditure, and in the long term they will reduce smoking related health care costs, releasing resources for other needs.

A recent international review[22] found the median societal cost of over 310 medical interventions to be £17 000 per life year gained discounted at 5% (standard economic practice weights immediately saved life years as more "valuable", and life years saved in the future as less valuable). Discounted results for smoking cessation interventions in the UK range from £212 to £873.[19] On these figures, even with conservative assumptions, smoking cessation interventions are considerably more cost effective than many medical interventions.

THE NHSE CLINICAL GUIDELINES PROGRAMME

The National Health Service Executive (NHSE) has published guidance on the development and promotion of clinical guidelines in the NHS.[23 24] They stress the importance of concentrating effort on areas likely to produce the greatest improvements in patient care, and distinguish five key reasons for choosing an area in which to develop clinical guidelines[23]:

(1) where there is excessive morbidity, disability, or mortality;
(2) where treatment offers good potential for reducing morbidity, disability or mortality;
(3) where there is wide variation in clinical practice around the country;
(4) where the services involved are resource-intensive (either high volume and low cost or low volume and high cost);
(5) where there are many boundary issues involved, sometimes cutting across primary, secondary and community care, and sometimes across different professional bodies.

Smoking cessation interventions meet all these criteria.

The NHSE stresses the importance of clinical guidelines being evidence based, involving the professions in their development, drawing on existing work from other countries in order not to duplicate effort, and being endorsed by relevant professional bodies. They also stress the importance of developing an implementation strategy as guidelines are developed, including the provision of training.

The NHSE publication *Promoting Clinical Effectiveness*[24] notes the importance of infor-

mation and monitoring. It recognises that health professionals need "good access to educational resources, library services, and learning events" but that "this also means providing clinical cover and protected time". It also notes the importance of continuing professional development and the responsibility of local NHS management to support the use of clinical guidelines. It recommends the *Effective Health Care Bulletins* and *Effectiveness Matters* bulletins published by the NHS Centre for Reviews and Dissemination. An *Effectiveness Matters* bulletin on smoking cessation[25] was published in March 1998.

NEW DEVELOPMENTS IN HEALTH CARE IN BRITAIN

A series of government policy papers have been published in the last year which will influence the development of the NHS as well as disease prevention within it. A White Paper, *The New NHS*,[26] includes proposed initiatives for a National Institute for Clinical Excellence (NICE) which will draw up guidelines based on evidence of effectiveness and cost effectiveness; Primary Care Groups (PCG) of local GPs and community nurses; and a Commission for Health Improvement to support the quality of clinical services at the local level.

From 1 April 1999 all GP practices (and their patients) will be represented within a Primary Care Group. PCGs aim to improve the health of the population they serve. They will provide a direct means by which GPs (and their team) and community nurses, working in cooperation with other health and social care professionals, will lead the process of commissioning high quality care for local people. PCGs may in time progress to become Primary Care Trusts (PCTs) that will be freestanding bodies separate from, but accountable to, their Health Authority.

The government will also establish a National Institute for Clinical Excellence to promote clinical and cost effectiveness through guidance and audit. It will establish a programme of evidence based National Service Frameworks to set out what patients can expect to receive from the health service in major care areas or disease groups. The Frameworks will set national standards and define service models for a specific service or care group, put in place programmes to support implementation, and establish performance measures against which progress within an agreed timescale will be measured. The first National Service Frameworks will deal with mental health and coronary heart disease. The importance of these cessation guidelines to these new initiatives is discussed further in Section 7 "Recommendations for health commissioners".

Our Healthier Nation, a Green Paper on public health,[27] emphasises growing inequalities in health and sets targets in four areas including heart disease and stroke, and cancer. Proposed national contracts in these areas will focus heavily on tobacco control measures. In addition, health authorities will lead local alliances to develop Health Improvement Programmes that will set out what each locality can do to support the national contracts for health. Health Action Zones have also been set up to bring together health organisations, including primary care, with local authorities, community groups, the voluntary sector, and local businesses to develop and implement locally agreed strategies. Finally, Healthy Living Centres, funded by the National Lottery, will provide opportunities for local community action to improve health and for individuals to take responsibility for improving their own health.

A White Paper on tobacco control[28] is currently being prepared. These guidelines will assist the development of the policies that are to be set out in the White Paper. Finally, the report of the Scientific Committee on Tobacco and Health[29] was published in March 1998 and recommended, inter alia, smoking cessation interventions by health care professionals, use of NRT, consideration of increased availability of NRT, and research on the efficacy and safety of NRT for pregnant smokers.

However these new NHS arrangements develop in practice, these clinical cessation guidelines and the cost effectiveness guidance will remain relevant as they set out what the health care system, both commissioners and providers, can do to promote effective and cost effective smoking cessation.

Why smoking cessation guidelines are needed

A 1995 HEA survey entitled *Health in England*[30] found that about 29% of smokers who had seen their GP in the previous year said they had been given advice on smoking. Even if this figure is an underestimate, there is a great opportunity for improvement. In a 1996 HEA survey[31] only 39% of pregnant smokers said they had received advice about smoking. The limited evidence that exists on the delivery of cessation help throughout the NHS suggests that it is patchy.[32] The conclusion is that smoking cessation is not yet integrated into routine NHS care, and that there is no national strategy or consensus on what should be done.

In the USA Fiore and colleagues[15] identified several barriers to action, including lack of time, perceived lack of skills, and the perception that success rates are low, something also found in the UK.[33] Not having time for something is another way of saying that it is a low priority. In the UK the 1990 health promotion contract offered GPs incentives to introduce basic smoking cessation tasks into their work. Payments were introduced for specific activities—for example, running smoking cessation "clinics"—and general practices had to submit details of the work being carried out. The quality of, and attendance at, such clinics varied greatly. This 1990 contract was replaced by a banded structure, with payments increasing according to level of associated health promotion activity. It is not known how effective either of these initiatives was in providing assistance for smokers wishing to stop.

The banding arrangement was replaced in October 1996 with one which does not specify particular health promotion activities (like smoking cessation). Practices are required to describe proposed health promotion activities

for approval by local health promotion committees. The committee makes a recommendation to the health authority as to whether the proposals should be approved for payment. Thereafter practices sign a form each year saying they are still conducting the same activities. Since smoking cessation is no longer a required activity, it is unsurprising if less is now being done on smoking cessation in primary care. The challenge remains to integrate smoking cessation into *routine* NHS care, and this will require the entire NHS to raise the priority given to smoking cessation activities.

The perception that cessation interventions are not effective may discourage some health professionals from intervening. Appreciating the difference between "success rates" and "reach" may help. Intensive treatments that achieve high cessation rates but reach limited numbers will usually produce fewer ex-smokers than less intensive approaches that reach many smokers.

Thus, brief advice from GPs (defined in the evidence table drawn from the AHCPR review as up to three minutes) may "only" encourage about 2% more smokers to stop compared with normal care control, but this apparently low figure, if applied nationally to all GPs, would be extremely worthwhile. Using very cautious and conservative assumptions, we estimate that if GPs advised an additional 50% of smokers to stop, using established protocols including the recommendation to use nicotine replacement therapy (NRT), it would lead to approximately 18 extra ex-smokers per year in a five partner practice, and an additional 75 000 extra ex-smokers a year nationally, at a cost of under £700 per life year gained.[19] The precise figures depend on the research study used, but the message is clear: **smoking cessation interventions are extremely worthwhile**.

Another barrier to action is access to research findings. A recent survey of GPs' opinions on evidence based medicine emphasises that their need is not so much for better access to libraries or information searching technologies which they have limited time to use, but for good quality summaries of evidence to be made available to them.[34]

Research, evaluation and monitoring

The movement towards evidence based medicine has resulted in a greatly increased emphasis on the need for good research.[35–38] Although these guidelines are based on methodologically rigorous research, there is an ongoing need for research to underpin, update, and improve clinical practice. We believe that a national research strategy is needed to support the development of smoking cessation services.

Research is needed to evaluate improved and new treatments, training, and implementation strategies. Given that GP advice is effective, there is reason to believe other health professionals can be effective in helping smokers to stop. More research is needed to evaluate the role of practice nurses, midwives, health visitors, pharmacists, health promotion specialists, and many others. We also know little about what happens if smokers use NRT to reduce rather than eliminate tobacco consumption,[39] and whether this could be an effective harm reduction strategy.[39 40]

Community based cessation interventions are more difficult to evaluate using randomised controlled trials. However, they have a valuable role to play both in stimulating cessation attempts and supporting cessation activities throughout the health care system, as we acknowledged at the beginning of the introduction. Furthermore, it is clear from the accompanying cost effectiveness guidance[19] that they may be very cost effective in producing health gain. Both their own effectiveness, and the ways in which they can link with clinical cessation efforts, require further research.

The NHSE stresses that common standards are needed to evaluate services and that effort is needed to monitor the outcome of local programmes.[23 24] Such local programmes[41] offer potential models for community wide smoking cessation services and qualitative as well as quantitative data are needed.[42] For example, No Smoking Day is a UK wide campaign which combines publicity and advocacy at a national and local level with support for smokers to stop. Local and national opportunities to raise awareness can support these recommendations by stimulating smokers to attempt to stop and seek support.

Finally, if service delivery is to improve, health authorities need to collect data on outcome and on costs to enable assessment of cost effectiveness.[19] Clinical audit needs to become standard practice if the impact of the recommendations in these guidelines is to be assessed.

2 Recommendations for the primary care team

About 90% of all contacts between people and the NHS take place in primary care.[38] Approximately 80% of people consult their GP about health at least once a year,[43] and the figure is higher for smokers.[17] For pharmacists the figures are even higher, with about 68% visiting their pharmacist at least monthly.[44] Dentists also see large numbers of patients, many of whom will have smoking related conditions. Thus, the potential for helping smokers in primary care is enormous. The cornerstone of the NHS smoking cessation strategy should be the *routine* provision of brief advice and follow up in primary care, including advice on NRT and how to use it.

Smokers who cannot stop with such an intervention should be offered further specialist treatment. Although this could be offered in a primary care setting, and some general practices do offer groups, the special skills required and the practical problems, including recruitment, make this an impractical option for most general practices. We recommend that smokers who need intensive help be referred to a specialist service (see Section 4).

Brief advice from a GP is effective.[15] Even if it "only" helps about 2% more smokers to stop (compared with normal care), applied nationally this would represent more than 18 extra smokers stopping in a five partner practice, or about 75 000 nationally (see page S7).

The recommendations below are for the primary care team. Teams will differ in how responsibilities and roles are divided. However, the centrality of the doctor-patient relationship and the respect people have for their doctor on health matters[43] means that the GP should have a central role, at least raising the issue and advising smokers to stop. Although more research is needed on the role of community pharmacists, they are also part of the primary care team[26] and are in a strategic position to offer smokers advice and support, especially since many smokers will be buying NRT from them.

Recommendations for the primary care team

1 **Assess the smoking status of patients at every opportunity; advise all smokers to stop; assist those interested in doing so; offer follow up; refer to specialist cessation service if necessary.**

2 **Recommend smokers who want to stop to use NRT and provide accurate information and advice on NRT.**

Strength of evidence: **A**

The essential features of individual smoking cessation advice in primary care (and other settings) are[45]:

Ask about smoking at every opportunity;
Advise all smokers to stop;
Assist the smoker to stop (see below);
Arrange follow up.

Ask All patients should have their smoking (or other tobacco use) status established and checked at every visit. A system should be devised to record smoking status in the notes. It should at least describe patients as smoker, non-smoker, or recent ex-smoker, and note any current interest in stopping. This record should be kept as up to date as possible. Interest in stopping can be assessed with an open ended question such as "Have you ever tried to stop?", which can be followed by a further question such as "Are you interested at all in stopping now"?

Advise All smokers should be advised of the value of stopping and the risks to health of continuing. The advice should be clear, firm, and personalised.

Assist If the smoker would like to stop, help should be offered. A few key points can be covered with the smoker in 5–10 minutes:

- Set a date to stop; stop completely on that day.
- Review past experience: what helped, what hindered?
- Plan ahead: identify likely problems, make a plan to deal with them.
- Tell family and friends and enlist their support.
- Plan what you are going to do about alcohol.
- Try NRT; use whichever product suits best.

Further advice could include offering a booklet on how to stop (the Health Education Authority's how-to-stop booklet *Stopping Smoking Made Easier*[46] includes practical advice on making an action plan, reasons for stopping, avoiding relapse, coping with stress, and gives a telephone help line number) and suggesting they talk to the pharmacist if they want further advice on NRT. All smokers can be recommended NRT. Further comments on NRT products can be found in Section 5. Information about *Stopping Smoking Made Easier* and other smoking cessation resources can be obtained in the first instance from local health promotion units.

Arrange Offer a follow up visit in about a week, and further visits after that if possible. Most smokers make several attempts to stop before finally succeeding (the average is around 3–4 attempts) thus relapse is a normal part of the process. If a smoker has made repeated attempts to stop and failed, and/or experienced severe withdrawal, and/or requested more intensive help, consider referral to a specialist cessation service. The Health Information Service (0800 665544) or the Quitline (0800 002200) will advise if there is one in the smoker's locality.

3 Recommendations for all health professionals

The involvement of health professionals in offering smoking cessation interventions should be based on factors such as access to smokers, level of training, experience, and commitment, rather than professional discipline. Most of the research on brief advice has been done with GPs because of their central role within the NHS which gives smokers such access to them. However, in much of the UK research on intensive cessation support the therapists were psychologists and specialist nurses, and the evidence reviewed in the AHCPR guideline[15] shows that many professions can give effective smoking cessation interventions. They reviewed 41 studies which compared different professions with either self-help materials alone or a no-intervention control and found evidence for the effectiveness of GPs, cardiologists, other physicians, dentists, nurses, pharmacists, psychologists, and social workers. The evidence does not strongly favour one profession over another (partly because trials are rarely set up to compare professions delivering identical interventions).

Health authorities will need to give careful consideration to the training needs of different professional groups, and the allocation of funding for training is a key recommendation for health commissioners (Section 7). We recommend that health authorities review training needs (Section 6) and that, in addition to the training provided by health promotion services which is typically in brief interventions, training should be a key function of a specialist cessation service (Section 4). There is also a need in the UK for more research on the role of practice nurses, midwives, health visitors, pharmacists, dentists, and dental hygienists in delivering smoking cessation interventions because of their wide access to smokers, and perhaps other professions also. We also believe that the sheer scale of the tobacco problem requires appropriate agencies to work together. Therefore, we support the recommendation made in *Our Healthier Nation*[27] that health professionals work in partnership with the voluntary sector.

The recommendations for primary care professionals are relevant to most health professionals.

Recommendations for all health professionals

3 Assess the smoking status of patients at every opportunity; advise all smokers to stop; assist those interested in doing so; refer to specialist cessation service if necessary; recommend smokers who want to stop to use NRT; provide accurate information and advice on NRT.

Strength of evidence: **B**

4 Recommendations for smoking cessation specialists

The cornerstone of the NHS smoking cessation strategy should be the routine provision of brief advice and follow up, including advice on NRT and how to use it (Section 5). These interventions should be integrated into primary care, and should also be delivered by as many health professionals and types of health profession as possible throughout the NHS (Section 3). Smokers who cannot stop with brief interventions should be offered further specialist treatment.[47] Although this could be located in general practices, this has not proved a popular or especially practical option,[48] and a district wide smoking cessation programme in which brief interventions in primary care are supported by a specialist clinic has been described and evaluated by Michael Russell and colleagues.[49 50]

Concern that intensive cessation treatment is not cost effective is misplaced. Intensive smoking cessation treatment is effective[15] and, like all smoking cessation interventions, extremely cost effective in producing population health gain, even more so than many medical interventions (Section 1).[19]

One of the main effects of brief advice is to motivate attempts to stop, rather than increase cessation rates. Many smokers cannot stop without more intensive help, and these will usually be heavier smokers, more at risk of smoking related disease. These are the smokers who most need specialist help.

Thus a specialist service would have at least two core functions: helping smokers who cannot stop with brief interventions; and training and supporting other health professionals to deliver smoking cessation interventions.

Summary of the evidence[3 5 15 47 48]

Intensive smoking cessation support with smokers motivated to stop, individually and in groups, is effective and cost effective. Treatment should deal with motivation to stop, techniques for coping with the urges to smoke, relapse prevention, and should include social support and offer follow up. Self-help materials may help. There is a dose response relationship between intensity of support and cessation rates (see evidence table). Cessation support can be effectively delivered by skilled and experienced professionals irrespective of discipline. All smokers should be offered or encouraged to use NRT unless there is a medical reason for them not to, or they do not want to try it.

Recommendations for smoking cessation specialists

4 **Intensive smoking cessation support should where possible be conducted in groups, include coping skills training and social support, and should offer around five sessions of about one hour over about one month, and follow up.**

5 **Intensive smoking cessation support should include the offer of or encouragement to use NRT, and clear advice and instruction on how to use it.**

Strength of evidence: **A**

Although evidence reviewed in the AHCPR guideline[15] shows a dose response relationship between intensity of support (length and content of sessions as well as duration of course) and cessation rates, practical constraints of time and funding will determine the service offered. The evidence does not strongly favour groups or individual therapy but, for a specialist service, groups have been the favoured approach and, other things being equal, they are much more cost effective. However, some smokers may not like or be able to attend groups, so that consideration should be given to individual therapy if needed.

The recommendations above are based on an approach to running groups developed in the UK over more than two decades and are well supported by published evidence of efficacy. Readers needing a more detailed description of the approach can consult Hajek.[51] The approach is summarised below. Details will be found in the guidance following these clinical guidelines[19] of the cost effectiveness of a specialist smoking cessation service.

Content of specialist cessation treatment[51]

People are normally treated in groups. This is partly for reasons of efficiency, and partly because it is believed that group members can motivate each other to maintain an attempt to stop. Those who for some reason do not want to be treated in groups, or are unable to attend groups, are offered individual treatment.

Five weekly evening sessions are offered over four weeks after the quit date. The first meeting is introductory with participants expected to stop after it and by the second session. NRT is distributed and discussed at the first session. From the second session meetings focus primarily on input from group members. They discuss their experiences of the past week, including difficulties encountered, and offer mutual encouragement and support. Sessions are client (not therapist) oriented, meaning that they emphasise mutual support rather than didactic input from the therapist. The therapist facilitates client interaction and mutual support outside formal sessions. During sessions there can be several conversations at the same time and, with this approach, groups can accommodate 20–25 participants and tend to work better with such numbers.

The carbon monoxide (CO) levels in expired air are measured at the beginning of each meeting. When the course is completed follow up meetings can be offered at various times, depending on resources available—for example, two, three, six, and 12 months from the beginning of the course. Sessions take about one hour on average and two therapists run the groups together if possible. Some form of self-help materials[46] may be provided.

5 Nicotine replacement therapy

Nicotine replacement therapy approximately doubles cessation rates compared with controls (placebo or no NRT), irrespective of the intensity of adjunctive support.[5 15] As a rule of thumb, in primary care it doubles cessation rates from approximately 5% to 10%, and in intensive settings from approximately 10% to 20%. All four NRT products (gum, patch, nasal spray, inhalator) have similar success rates, and there is no controlled trial evidence yet favouring one product over another. Evidence is emerging on the effectiveness of combinations of NRT products,[52] and for other pharmacological treatments, such as bupropion.[53] NRT is safe[54] and few become long term users. It should be routinely recommended to smokers, the choice of product depending on practical and personal considerations.

NRT costs approximately the same as the average cost of smoking (about £17 per week). This has been used to argue that smokers must therefore be able to afford NRT. Although this may be true for many, it overlooks a number of points. It assumes that all smokers can afford to smoke. In the UK the highest smoking rates are found in the most disadvantaged people, who spend around 14% of their disposable income on tobacco,[55] and also find it more difficult to stop. Were NRT available on prescription the effect for these smokers is that it would be free. It has also been shown that cost affects uptake and acts as a deterrent to NRT use.[56]

Concern that NRT costs would prove excessive were it to be made available free to smokers by the NHS may be overstated. The proportion of smokers who continue trying to stop once a cessation attempt has begun is not high, so that most NRT use is of fairly short duration.[57]

At the moment all NRT products except the nasal spray, which is available only on private prescription, can be purchased from pharmacies without prescription. NRT products are not available for sale outside pharmacies in Britain. Research in the USA, where there is no pharmacy-only class of medicines, showed that removal from prescription-only control increased uptake of NRT products, which would suggest an increase in cessation attempts.[58] However, there is no professional support and it is known that overall cessation rates go up as more support is given. There therefore remains a crucial role for health professionals to give support to smokers trying to stop, including advice on the appropriate use of NRT.

Recommendations

6 Smokers should be encouraged to use NRT as a cessation aid. It is effective and safe if used correctly.

Strength of evidence: **A**

7 Health professionals who deliver smoking cessation interventions should give smokers accurate information and advice on NRT.

Advice on the use of NRT is summarised in this section, including who should and should not use NRT. Most of this summary could be reproduced as a general advice sheet for smokers.

Box 1 Nicotine replacement advice sheet

Nicotine replacement therapy (NRT) can help smokers stop, even if they have tried it before.

- Clinical trials have shown that NRT doubles the chance of success of smokers wishing to stop.
- NRT is not a magic cure. It does not provide a complete replacement for cigarettes, nor replace the need for willpower. But when you are abstinent, it will help with the craving and withdrawal.
- NRT usually provides nicotine in a way which is slower and less satisfying, but safer and less addictive than cigarettes.
- Although NRT provides nicotine it does not contain tar and carbon monoxide as tobacco smoke does. There is no evidence as yet that nicotine causes cancer.
- NRT reduces withdrawal symptoms like irritability, depression, and craving, although it does not eliminate them entirely.
- Very few people become addicted to NRT. Some ex-smokers continue to use it for a year or more but this is mainly because of concern about returning to smoking.
- For the best results NRT should be used in sufficient quantities and for long enough. Smokers should follow the instructions in the package and seek advice from the pharmacist if more information is needed.

Which product?
All four NRT products have similar success rates, therefore the choice between them is a practical and personal one. The patch is easier to use, and some people do not like chewing gum. The gum, nasal spray, and inhalator permit more control over the dose and how quickly it is obtained. The nasal spray is only available on private prescription. The patch, gum, and inhalator can all be bought (over the counter) from the pharmacist, and cost approximately the same as 20 cigarettes a day.

Who should use NRT?
Except for medical reasons NRT can be used by all smokers. Although most NRT research has been done with people who smoke at least 15 a day, the patch and 2 mg gum appear to be effective with lighter smokers in research trials.

Who should not use NRT?
Expert opinion currently is that NRT is likely to be safer than smoking.[59] However, the current position in the UK is that pregnancy is a contraindication for the use of most NRT products. Basically the same applies to smokers with cardiovascular disease, although NRT is not an independent risk factor for acute myocardial events. With several NRT products in the UK the package inserts advise people who have heart disease (and some other specified conditions) not to use the products without first talking to their pharmacist or doctor. The health professional can then make a risk assessment bearing in mind that there is good evidence for secondary prevention of ischaemic disease even following a myocardial infarct.

The position is less clear with young people. Some products—for example, the patch and the inhalator—are not recommended for people under 18, but this restriction does not appear on the gum labelling.

Box 2 Which product?

The **nicotine skin patch** is the easiest to use. It is put on each morning, is designed to be worn for 16 or 24 hours, and comes in different doses. Unless smokers smoke fewer than 10 cigarettes a day, they should normally use the highest dose patch.

Nicotine gum comes in 2 mg or 4 mg doses and in traditional, mint, and other flavours. The taste can be unpleasant at first but most people get used to it in a week or so. It is important to chew slowly to get the most out of the gum because any nicotine that is swallowed is wasted. The nicotine has to be absorbed through the mouth. Heavy smokers should consider using the 4 mg gum.

Nicotine nasal spray consists of a small bottle of nicotine solution. When the top is pressed down it delivers a dose of nicotine in a spray. Nicotine is absorbed faster than from the patch, gum or inhalator, and this can be better for more addicted smokers. However, it can be difficult to get used to because the spray can irritate the nose. Smokers who still experience severe craving and withdrawal with the other NRT products should try the nasal spray.

The **nicotine inhalator** consists of a plastic mouthpiece and a supply of nicotine cartridges that fit on the end of it. Smokers draw on it like a cigarette. Despite its name, the nicotine does not reach the lungs but stops in the mouth and throat. The inhalator delivers nicotine in a way very like the gum.

6 Other populations and topics

Hospital patients

Smoking cessation interventions with hospital inpatients help about 5% more smokers to stop compared with no treatment/usual care (see evidence table on page S4). Thus, the evidence supports providing cessation help for smokers in hospital. We recommend the same basic approach for hospital staff as for other health professionals—that is, to ask, advise, assist, and arrange help if needed, including the provision of NRT.

A hospital visit should be treated as an opportunity to help smokers stop, especially since smoking can interfere with recovery,[15] and evidence is accumulating of the benefits of stopping smoking before surgery,[60] radiotherapy,[61] and in people with smoking related disease.[18] Making hospitals smoke free should be a priority for health commissioners and managers (see Section 7). Putting in place systems to establish the smoking status of all patients, and the provision of at least a brief intervention, should be a priority for hospital managers. Such procedures might eventually have an impact on the way smokers are treated during their stay in hospitals. We therefore recommend that all relevant hospital services, wards and clinics regard smoking status as a vital sign and routinely record it for all patients. There will be some exceptions—for example, some psychiatric settings and patients with lung cancer.

Recommendations

8 Hospital staff should assess the smoking status of patients on admission, advise smokers to stop, and assist those interested in doing so. Patients should be advised of the hospital's smoke free status before admission.

Strength of evidence: **C**

9 Hospital patients who smoke should be offered help in stopping smoking, including the provision of NRT.

Strength of evidence: **A**

Pregnant smokers

Smoking cessation interventions during pregnancy are effective (see evidence table on page S4) and should be used routinely. There is some evidence of the effectiveness of advice with literature and some follow up for pregnant smokers, and stronger evidence for more intensive interventions—for example, a structured cessation course based on self-help booklets.[62] The AHCPR meta-analysis of counselling, defined as 10 minutes or more contact supplemented by self-help materials and/or referral to intensive support, showed an approximate doubling of cessation from about 8% (no intervention or usual care) to about 15%.[15]

This is a difficult issue for health professionals, however, and there are many barriers to good practice.[63] There is, furthermore, evidence that some health professionals are reluctant to advise outright cessation rather than cutting down, but cutting down is of little, if any, benefit.[64] Outright cessation should therefore be advised. The consultant obstetrician, as well as midwives, should play a leading role in raising the issue.

More research is needed in the UK to establish under what conditions health professionals can give effective support to pregnant smokers, and the training and other structural factors that need to be addressed. These are issues for the professions and for health commissioners.

The Health Education Authority has published a guide on smoking and pregnancy for health professionals which includes leaflets for the smoker and her partner designed to be used in the counselling of pregnant smokers.[65]

Benowitz[59] concluded that the benefits of NRT outweigh the risks of smoking for pregnant smokers, but suggests that NRT only be offered to pregnant smokers if they cannot stop without it. However, in the UK at the moment most NRT products are specifically contraindicated for pregnant smokers (see Section 5, "Who should not use NRT?").

We endorse the recommendation of the report of the Scientific Committee on Tobacco and Health[29] for a clinical trial on the efficacy and safety of NRT for pregnant smokers.

Recommendation

10 Pregnant smokers should be given firm and clear advice to stop smoking throughout pregnancy, and given assistance when it is requested.

Strength of evidence: **A**

Young people

Young people can become addicted to tobacco very quickly[66] and many want to stop smoking.[67] There is little research evidence of effective cessation programmes with young people to date, but health professionals clearly cannot ignore their needs. We recommend that young people should be offered the same brief interventions as adults (see Sections 2 and 3), but in a way appropriate to their age. There are as yet no trials of NRT with young people but there seems no reason why they should not use it. Some of the NRT products specifically exclude young people whilst some make no such caution.

Recommendation

11 Cessation interventions shown to be effective with adults should be considered for use with young people, with the content modified as necessary.

Strength of evidence: **C**

Low income smokers

In principle, low income smokers have the same access to GPs, to smokers' clinics, and to free telephone help lines as other smokers,

although in practice the most disadvantaged may have difficulties with, for example, the cost of transport to services. The most disadvantaged do not, however, have access to NRT, a treatment of proven efficacy, because of its cost.[55] The effect of making NRT available on NHS prescription would be to make it free to them, as the vast majority would be exempt (about 14% pay prescription charges). This situation is also anomalous in view of the proven efficacy of this treatment, and the special need of the most disadvantaged, in which smoking prevalence rates are around 75%.[55] Since it has also been shown that cost affects uptake and acts as a deterrent to NRT use,[56] the clear policy recommendation for this group is that NRT should be made available to them.

Recommendation

12 Consideration should be given to ways of increasing the availability of NRT to low income smokers, including at a reduced cost or free of charge.

Strength of evidence: **C**

Sex

Epidemiological as well as treatment studies show no significant differences in cessation rates between men and women.[68] However, few studies have so far been designed to look specifically at sex differences in treatment needs and outcomes. Thus, the state of the evidence so far is that the cessation approaches recommended in this guide benefit men and women and can be recommended to both.[15]

Weight gain

Most smokers who stop increase weight, mostly by not more than about 10 lbs, but with about 10% gaining as much as 30 lbs.[69] Smokers can be advised that weight increases of this order present a negligible threat to health compared with the risks of continuing smoking. However, for many smokers the weight gain is aesthetically unacceptable. Weight gain appears to be caused both by more efficient uptake of food nutrients and by increased eating and drinking, and although nicotine replacement only delays the weight gain, this can help smokers until they feel confident enough to tackle the weight separately.[15] The possibility of weight gain on stopping should be acknowledged, and smokers should be encouraged to delay dealing with the gain, if possible, until they are confident of remaining non-smokers. They can be advised that NRT helps delay weight gain.

Other treatments

A wide range of treatments have been tested as aids to smoking cessation, and some of them—for example, hypnosis and acupuncture—have a high profile and tend to be sought after by smokers. Many are promoted commercially, some with unproven claims for effectiveness, some with little evidence of efficacy over and above a placebo effect. However, a placebo effect can be extremely valuable. Health professionals should give smokers enough information about other treatments to enable them to make an informed choice, but without discouraging attempts to stop. The issue for the health service is different because of its obligation to use public money effectively and promote evidence based medicine. We have therefore listed a range of treatments for which there is as yet insufficient evidence of efficacy to recommend them.

We cannot currently recommend that the NHS offers aversive smoking (insufficient evidence of efficacy[7]), hypnosis (insufficient evidence[14]), acupuncture (evidence that it only works as a placebo[8]), clonidine (evidence for effectiveness but side effects so not recommended as a first line treatment[9]), anxiolytics and antidepressants (insufficient evidence[11]), lobeline (inadequate evidence for efficacy[10]), silver acetate (inadequate evidence for efficacy[12]).

The carbon monoxide monitor has been used as part of a package of evaluative and/or motivational components in smoking cessation studies, but there is as yet no scientific evidence of effectiveness when used on its own. However, it can have a strong motivating effect on smokers and is an important tool for confirming abstinence.

No Smoking Day

No Smoking Day is a UK wide campaign which combines publicity and advocacy at a national and local level with support for smokers to stop. It has been estimated that about one million smokers take part and 40 000 stop smoking.[70] Local and national initiatives which raise awareness can support these recommendations by stimulating smokers to attempt to stop and seek help.

Telephone help lines

In England a telephone help line, the Quitline, funded by the Health Education Authority, is available free to callers throughout the country and can be accessed outside surgery hours. Very few trials have investigated the effectiveness of telephone help lines on their own, but the AHCPR meta-analysis finds a significant effect. However, telephone help lines are difficult to evaluate in isolation,[71] but they do seem likely to provide a valuable service to smokers and it makes sense, where they exist, to advertise and make full use of them. Randomised trials to determine effectiveness are needed. Evidence is also presented in the AHCPR guideline for a modest but significant effect for self-help materials.[15]

Training

Health professionals who have received training are significantly more likely to intervene with smokers than those who have not been trained.[6] There is also evidence, though less strong, that smokers are more likely to stop if seen by health professionals trained in smoking cessation.[6] Thus, there is a clear case for training health professionals both to give effective smoking cessation interventions and to increase their inclination to intervene. There is also a case for emphasising the role of health professionals as non-smoking models to their patients.[15]

The Health Education Authority's national training programme "Helping People Change" has been very widely disseminated. However, a key issue with training is whether, after they have been trained, primary care professionals continue intervening with smokers.

Training needs to be supported by systems which ensure health professionals have access to it and support them in continuing to use new skills. This includes proper funding, locum replacements, and follow up.[23] It is not enough for training to be left to occasional courses offered on a voluntary basis to health professionals able to get time off, as tends to be the case at the moment. This is an issue for commissioners and managers, who must fund training in smoking cessation as a core health care activity (see Section 7, recommendation 18).

Finally, training on smoking cessation should not be left until after qualification. Smoking and smoking cessation should be part of the core curriculum of basic training of all health professionals.

Recommendations

13 Smoking and smoking cessation should be part of the core curriculum of the basic training of all health professionals.

14 Training should be a core part of a smoking cessation programme in all health authorities. Protected time and funding should be built into this programme.

Strength of evidence: **B**

Thorax 1998;**53** (Suppl 5, Part 1):S16–S17

7 Recommendations for health commissioners

Few medical interventions are as cost effective as smoking cessation in producing population wide health gain. In the figures given in the Introduction the most expensive smoking cessation intervention is considerably more cost effective per life year gained than the average of more than 300 medical interventions.[19] Further details can be found in Part 2 of this supplement.[19]

Before setting out the recommendations for health commissioners (health authorities and primary care groups), we briefly suggest some of the ways in which these cessation guidelines can be used within the new NHS structures.

Health authorities

Every health authority is required to have a Health Improvement Programme. This is a strategic mechanism for achieving health and health service targets. These guidelines should be incorporated into all Health Improvement Programmes.

Health authorities should consider the opportunities for PCGs to collaborate to serve a larger population—for example, in developing a specialist smoking cessation service (see Section 4). The contribution of PCGs to specific diseases through smoking cessation should be incorporated within the annual accountability framework or agreements made between health authorities and PCGs.

Health authorities should also consider with PCGs and Primary Care Trusts (PCTs) how the training needed to develop effective smoking cessation services will be included in District Workforce Planning and Training Programmes.

Primary Care Groups

PCGs and PCTs need to consider these guidelines both with respect to commissioning services and also specifically in relation to their part in developing the role of primary care teams and others in disease prevention and health promotion. Primary care teams and other health professionals can make an important contribution to national targets. These guidelines define evidence based practice which will ensure that the work of primary care and other health professionals is effective and optimal.

Clinical governance and national service frameworks

Smoking cessation interventions should also be specified within clinical governance arrangements. Effective practice should be defined, developed and reviewed. In the context of clinical governance, smoking cessation should also be included in the training and development plans for health professionals.

These guidelines are intended to be incorporated within future national arrangements to ensure quality and effectiveness by the NHSE. They define the effective smoking cessation practice that should be incorporated into the national service frameworks.

Recommendations

15 To produce cost effective significant health gain in the population, smoking cessation interventions should be commissioned.

Strength of evidence: **A**

The choice of intervention will depend on many factors. The cost effectiveness data show that core smoking cessation interventions, including brief GP advice and more intensive support, are extremely cost effective.

The recommendations in this section, if implemented, would increase the chances of health professionals developing the skills and commitment to give more effective cessation support to smokers who come into contact with the system, which in practice is almost all smokers.[17] However, it is essential that smoking cessation—identifying smokers and intervening with them—be made a core health care activity, and this means that funds will have to be found, perhaps diverted from ineffective or less cost effective treatments.

16 Review current practice, identify needs, and provide core funding to integrate smoking cessation into health services; plan a cessation strategy with public health specialists; seek advice from smoking cessation specialists.

Strength of evidence: **A**

Health professionals should be involved in the planning process. The content of the services that could be provided is described in more detail in the preceding sections. The overall goal should be that, in each Health Authority, the identification of smoking status and offer of simple advice should be routine in primary health care and in other parts of the service. Practices able to offer further support to smokers should do so. Smokers who want to stop but cannot do so without more intensive treatment should be offered it by a specialist service which each authority should provide.

Advice on smoking cessation, including designing and setting up specialist services, can be obtained from several specialists in the UK, including many involved in the writing and reviewing of these guidelines.

17 These plans should include a specialist cessation service.

Strength of evidence: **A**

Intensive smoking cessation treatment is effective.[15] Such a service would have at least two core functions: helping smokers to stop who do not respond to less intense interventions in primary care; training and supporting

other health professionals in the authority; some centres may also do treatment research (see Section 4).

Although simple advice offered in primary health care should be the cornerstone of the smoking cessation strategy of the health service, there is a gap between achievement of this goal and the potential of primary health care (see Introduction). One way of improving the situation is to provide primary health care staff with specialist support and training.

18 Core fund smoking cessation training, or make sure that smoking cessation is prioritised within existing training budgets.
Strength of evidence: **B**

Training improves the likelihood of health professionals intervening with smokers,[6] and smokers seen by health professionals who have received training are more likely to stop than those seen by professionals not trained.[6] However, providing training is not enough. It is crucial to put in place structures and incentives to promote training and to ensure its effects are not transient. The NHSE guidance on implementing clinical guidelines stresses the importance of providing protected time for training and of funding for locum replacements.[23]

19 Make provision to ensure that NRT is available to hospital patients who need it, in conjunction with professional advice and cessation support.
Strength of evidence: **A**

Both NRT and hospital based cessation are effective. A hospital stay will be a valuable opportunity for many smokers to stop, so the funding of NRT from existing hospital budgets would be worthwhile.

20 Require all services, departments, and clinics, to introduce systems to maintain an up to date record of the smoking status of all patients in their (paper or electronic) notes. It should be regarded as a vital sign.
Strength of evid ence: **A**

Recording the smoking status of all patients increases smoking cessation interventions by health professionals[15] and seems a logical precursor to further interventions. The systems should promote liaison between different clinics, services, and professions to try to improve continuity of care. In line with the NHSE recommendations,[23 24] health authorities need to collect data on what is being done and on costs. When more data are collected locally it will be easier to plan the cessation services best suited to your health authority. Computer systems should ensure that, when a patient's notes are called up, smoking status is always displayed.

21 Ensure that all health care premises and their immediate surroundings are smoke free.
Strength of evidence: **C**

This is consistent with official guidance to the NHS on smoke free health premises[72] and with the goal of health services to promote health. Experience in the UK shows that the transition to smoke free health care premises will take time. Health authority managers should also consider offering advice and support to staff who wish to stop smoking, especially in view of the potential of health professionals as non-smoking role models to their patients.[15] Although there may be exceptions to the general smoke free rule (possibly in the mental health field), they should be rare.

22 Work with clinicians to put systems in place to audit smoking cessation interventions throughout the health care system.

It is important to measure the impact and the costs of new interventions. All the recommendations in these guidelines should be accompanied by the introduction of clinical auditing to assess the impact of changes in procedures.

These guidelines are being assessed for incorporation within future national arrangements for quality and effectiveness by the NHSE.

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