STOP SMOKING INTERVENTIONS IN PHARMACY

Service Specification

1. INTRODUCTION

1.1 National/local context and evidence base

Smoking remains the single largest cause of preventable deaths and one of the largest causes of health inequalities in England. There are still 7.3 million adult smokers and more than 200 people a day die from smoking related illness which could have been prevented.

As well as dying prematurely, smokers also suffer many years in poor health. Many of the conditions caused by smoking are chronic illnesses which can be debilitating for the sufferer and make it difficult to carry out day to day tasks and engage with society and the economy. Smokers proportionately are less likely to be in work.

The impact of smoking in Plymouth

Tobacco use is the primary cause for health inequalities. (Wanless, 2004). The difference in life expectancy between the wards with the highest and lowest life expectancy values in Plymouth was 7.7 years for the period 2014-16, ("Life Expectancy in Plymouth", Office of the Director of Public Health, 2017).

Smoking currently causes around 313 preventable deaths in Plymouth every year and is estimated to cost Plymouth's economy in excess of £60 million per year.

Smoking costs the NHS in Plymouth around £4m per year

In 2016/17, there were approximately 2,683 smoking related hospital admissions with smokers also seeing their GP 35% more than non-smokers. These costs add a great burden to a system already dealing with growing demand.

Smokers are, on average, absent from work 2.7 days more per year compared to ex and non-smokers. Smoking breaks also result in lost output for employers.

Smoking-related ill health also leads to increased costs for the adult social care system. The total additional spending on social care for Plymouth amounts to an estimated £8 million per year.

Smoking Prevalence in Adults (+18)	Indicator Value
Plymouth	17.2%
England Average	15.5%

Table 1.1 Source: Public Health Outcomes Framework, 2018 (https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/0 Accessed February 2018)

Plymouth has a higher mortality rate attributable to smoking than the national average.

Smoking Attributable Mortality rate per 100,000 population, 2014-16	Indicator Value
Plymouth	312.4
England Average	272.0
South West Region Average	234.7

Table 1.2 Source: Public Health England Local Tobacco Control Profiles for England, 2018

Therefore the provision of a high-quality local stop smoking services and effective local tobacco control interventions are a fundamental priority in reducing health inequalities and improving health among the communities of Plymouth. This PHS will provide clients with an additional option for accessing support to smoking cessation. The more availability and greater options for clients the more likely it is to lead to an increase in uptake of smoking cessation support.

This Service Specification directly contributes to reducing the smoking prevalence in adults, which is a Health Improvement indicator of the Public Health Outcomes Framework.

2. PURPOSE

Helping people to stop smoking.

The overall aim of this PHS is to support the reduction of smoking prevalence in Plymouth and reduce health inequalities by increasing access to high quality, evidence based support. It will achieve this by providing additional options of access to stop smoking support in the Pharmacy setting.

The PHS will also support the achievement of Health Improvement Smoking Cessation quitter targets as defined by ODPH within PCC.

3. SERVICE DESCRIPTION

3.1 Key activity

The Smoking Cessation Guidelines (Appendix 2) must be followed in delivering this PHS. The pathway shall include the following elements:

1. The Practice will arrange an initial appointment for each patient wishing to use the Community Pharmacy's stop smoking service to set a quit day (20-30 minute appointment).

2. Patients should be seen in-house. The Pharmacy shall provide a consultation room that offers suitable privacy and confidentiality to the client and use this when consulting the client for this service (unless the client does not wish to do so, or the pharmacist believes this would threaten his or her safety).

3. NRT can be recommended and issued by the pharmacy (in line with the SWDFR). Any NRT issued must be recorded on PharmOutcomes and overseen by an appropriate Pharmacist for purposes of clinical responsibility. (See Appendix 3 for 'Medication Protocol for Pharmacy PHS').

4. Varenicline can be recommended by the pharmacy (in line with the SWDFR). A signed letter of recommendation (LoR) (Appendix 4) should be given to the patient where suitability for the medication has been checked by an appropriate pharmacist. (See Appendix 3 for 'Medication Protocol for Pharmacy PHS').

5. The Pharmacy will arrange two follow-up appointments over the 8 week treatment programme in line with the SWDFR prescribing recommendations (10-20 minute appointments).

6. The Practitioner will CO validate with a smokerlyser at each consultation. All quits will be verified by a smokerlyser which will be provided free of charge to the Community Pharmacy by the Livewell South West WellBeing Team.

7. Where the quit is unsuccessful, clients may be seen again under this PHS. In these cases, the client's readiness to quit should be assessed prior to providing NRT and support (in line with the SWDFR).

3.2 Eligibility criteria

Residents and visitors to Plymouth who would like support to stop smoking in the Pharmacy setting.

Appropriate Community Pharmacies eligible to provide this PHS will be selected based on location & demographic access.

In addition, Pharmacies must be able to demonstrate that they meet the following requirements, prior to initiation of this contract:

1. Staffing requirements – see section 4.3
2. IT – access and user knowledge of PharmOutcomes
3. Resources – ready access to a suitable consultation room, smokerylyser CO monitoring equipment and publicity material.

The Practitioner will refer to Livewell South West Well Being Team any smoker whom the Practitioner feels would benefit from more intensive specialist support that can be offered in the Community Pharmacy. This may include under 18's, pregnant women, adolescents, those with specific diseases (e.g. COPD or CVD), smokers with mental health problems or learning difficulties and people who are heavily addicted to nicotine.

The Practitioner will apply any exclusion criteria as described by SWDFR. For information on clinically relevant medications that interact with smoking please see 'Which medicines need dose adjustment when a patient stops smoking?' (Appendix 5).

Patients should be assessed for suitability of recommended smoking cessation medications.

The advice of the Livewell Southwest Wellbeing Team may be sought by the Practitioner at any time.

3.3 Referral routes

This service is available to residents and visitors to Plymouth who would like support to stop smoking in the General Practice setting.

3.4 Access to the service

This PHS will be available within normal Pharmacy opening hours.

4. NETWORKS AND LINKS

This PHS will act as part of a coordinated city wide Stop Smoking Service and is therefore interdependent with the core smoking cessation 'specialist service' located within the LSWWBT. The Specialist Service will:

1. Provide advice to the Community Pharmacy at any reasonable time

2. Provide training to act under this PHS

3. Provide each Pharmacy providing this PHS with a smokerlyser free of charge for use in delivering this Service

4. Be available (in the form of the LSWWBT see Appendix 1) to provide expert advice and support to Practitioners.

5. Provide feedback to the Pharmacy practice in relation to smoking cessation activity and the number of CO verified 4 week quitters.

6. Send quarterly outcome data of the individual's quit attempt to the LPC upon receiving qualifying monitoring data.

5. OTHER KEY TASKS

Ensure that the relevant Pharmacist takes clinical responsibility for all Nicotine Replacement Therapy (NRT) medications that are issued to clients on behalf of the relevant Pharmacy. For information on clinically relevant medications that interact with smoking please see 'Which medicines need dose adjustment when a patient stops smoking?' Appendix 5.

It is recommended that the responsible Pharmacist undertakes and completes the relevant CPPE Smoking Cessation Training (see 'Staff Training').

Advertise the availability of support to stop smoking within the Community Pharmacy (posters can be obtained from smokefree nhs website).

Use PharmOutcomes to monitor and register all smoking cessation PHS activity. All monitoring data, where possible, should be given consent by the patient (registered in PharmOutcomes) to enable LSWWBT to follow up outcomes and service evaluation. The monitoring data should contain details of all NRT medications issued and be overseen by the relevant Pharmacist.

Ensure that all appropriate Community Pharmacy staff regularly refer smokers who are ready to quit to either their in-house stop smoking practitioner or to the specialist service as per the Smoking Cessation Guidelines (Appendix 2).

Accurately inform patients about NRT and other pharmacotherapies as recommended by the SWDFR, and recommend/issue medications as appropriate ensuring that the patient is offered choice of where to receive the help they need to quit smoking as identified in the Smoking Cessation Guidelines (Appendix 2). Follow up will be required and monitoring data registered on PharmOutcomes in all circumstances.

Make contact with patients 'lost to follow-up'. This will require a minimum of 2 telephone calls or other contacts to ascertain quit status.

Validate quit attempts with a CO reading. (CO readers will be issued and maintained by Livewell Southwest Wellbeing Team see 3.5).

Insurances

The pharmacy contractor and / or pharmacists are responsible for ensuring that professional indemnity insurance arrangements are in place for the operation of the enhanced service.

The pharmacy and accredited pharmacist must report any incidents, near-misses and complaints relating to this service according to their organisational policies and procedures and also communicate this to Plymouth City Council

The advice of the Livewell Southwest Wellbeing Team may be sought by the Practice at any time.

6. STAFF

Staffing requirements

It is recommended that the responsible Pharmacist undertakes and completes the following CPPE Smoking Cessation Training:

Stop Smoking NCSCT stage 1 and 2 assessment

This course is available online at - **http://www.cppe.ac.uk**

At least one person per Community Pharmacy will attend a 1- day workshop (Community Practitioner Training for Pharmacies) run by the Livewell South West Well Being Team before providing services under this PHS. The training will be run to NCSCT required training standards. Anyone who has attended training from other Stop Smoking Services or from the Maudsley Clinic would be able to practice providing they have continued to update their knowledge and skills through annual updates at the discretion of Livewell South West Well Being Team.

Practitioners are expected to attend at least one on-going training session annually to ensure they are kept up to date with new evidence and research.

7. SERVICE VOLUMES

Remuneration will be paid by the Commissioner to the Provider as follows, and in line with the payment process as specified in Annex 3:

1st consultation (setting quit day)	**30 minutes**	**£10.21**
2nd consultation (check up)	**20 minutes**	**£ 7.66**
3rd consultation (4 week follow up)	**20 minutes**	**£ 7.66**
Payment per CO validated quitter at 4-weeks		**£ 5.11**
Therefore, the total payable for maximum achievement is		**£30.64 per quitter.**

All NRT will be reimbursed at current drug tariff prices plus 5% for VAT less any prescription charges taken.

Other costs:

No additional remuneration is available for Practitioners' time spent training etc.

No additional remuneration is available for other Community Pharmacy staff members' time in relation to this PHS.

8. PERFORMANCE

8.1 Outcomes
Locally agreed outcomes and quality requirements

Outcome	Measure	Annual Target	Evidence Source	Reporting mechanism
Smoking Prevalence – Adult (over 18)	Number of CO verified 4 week quitters (%)	N/A	Monitoring Forms sent to Livewell Southwest Wellbeing Team (Appendix 1)	PhamOutcomes

9. QUALITY REQUIREMENTS
NICE (2008) Stop smoking services Public health guideline 10 www.nice.org.uk/guidance/ph10

NICE (2013) Tobacco: harm-reduction approaches to smoking. Public health guideline 45 www.nice.org.uk/guidance/ph45

Applicable local standards
It is the responsibility of the Pharmacist at each provider site to satisfactorily comply with his or her obligations under Schedule 1 of the Pharmaceutical Services Regulations to provide essential services and implement an acceptable system of clinical governance.

Appendix 1 SWDFR
Appendix 2 Smoking Cessation Guidelines
Appendix 3 Medication Protocol for Pharmacy PHS
Appendix 4 Pharmacy PHS Letter of Recommendation for Varenicline
Appendix 5 Which medicines need dose adjustment when a patient stops smoking?

10. CONTRACT MANAGEMENT
Contract Monitoring and Management Arrangements

All smoking cessation activity delivered under this PHS should be registered appropriately on PharmOutcomes.

Review meetings will be arranged by mutual agreement between the provider and the commissioner as required.

Consenting clients may be asked to complete a customer satisfaction survey as coordinated by Livewell South West Well Being Team

Delivery Location

As set out in original contract and subsequent variations to that contract.

APPENDICES

Appendix 1 Livewell South West Well Being Team
Appendix 2 Smoking Cessation Guidelines
Appendix 3 Medication Protocol for Pharmacy PHS
Appendix 4 Pharmacy PHS Letter of Recommendation for Varenicline
Appendix 5 Which medicines need dose adjustment when a patient stops smoking?

Appendix 1 Livewell South West Well Being Team

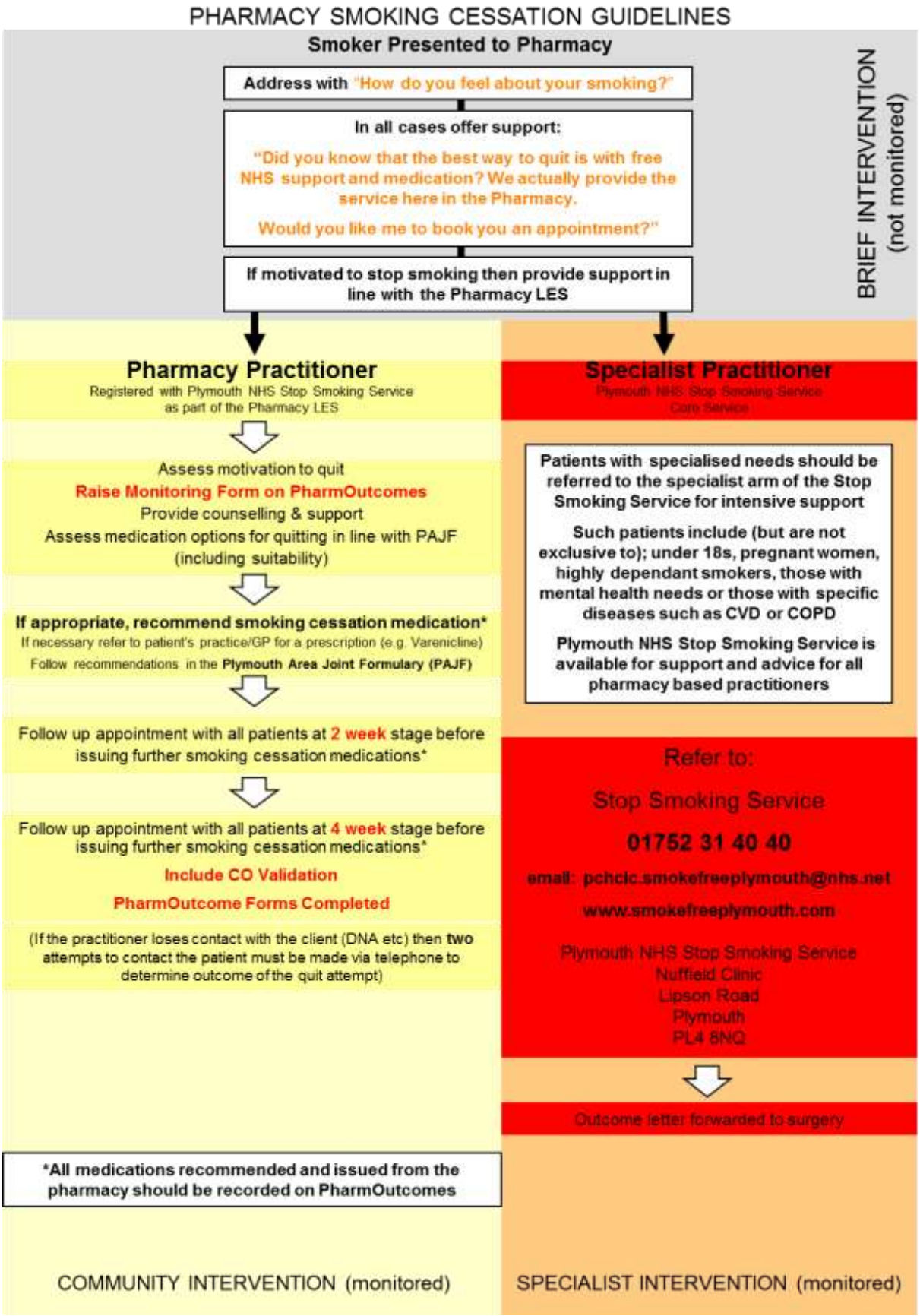
Contact details:

Livewell Southwest Wellbeing Team
Mount Gould Admin Block
200 Mount Gould Road
Plymouth
PL4 7QD
Telephone 01752 437177
Email: oneyou.plymouth@nhs.net
Website www.oneyouplymouth.co.uk

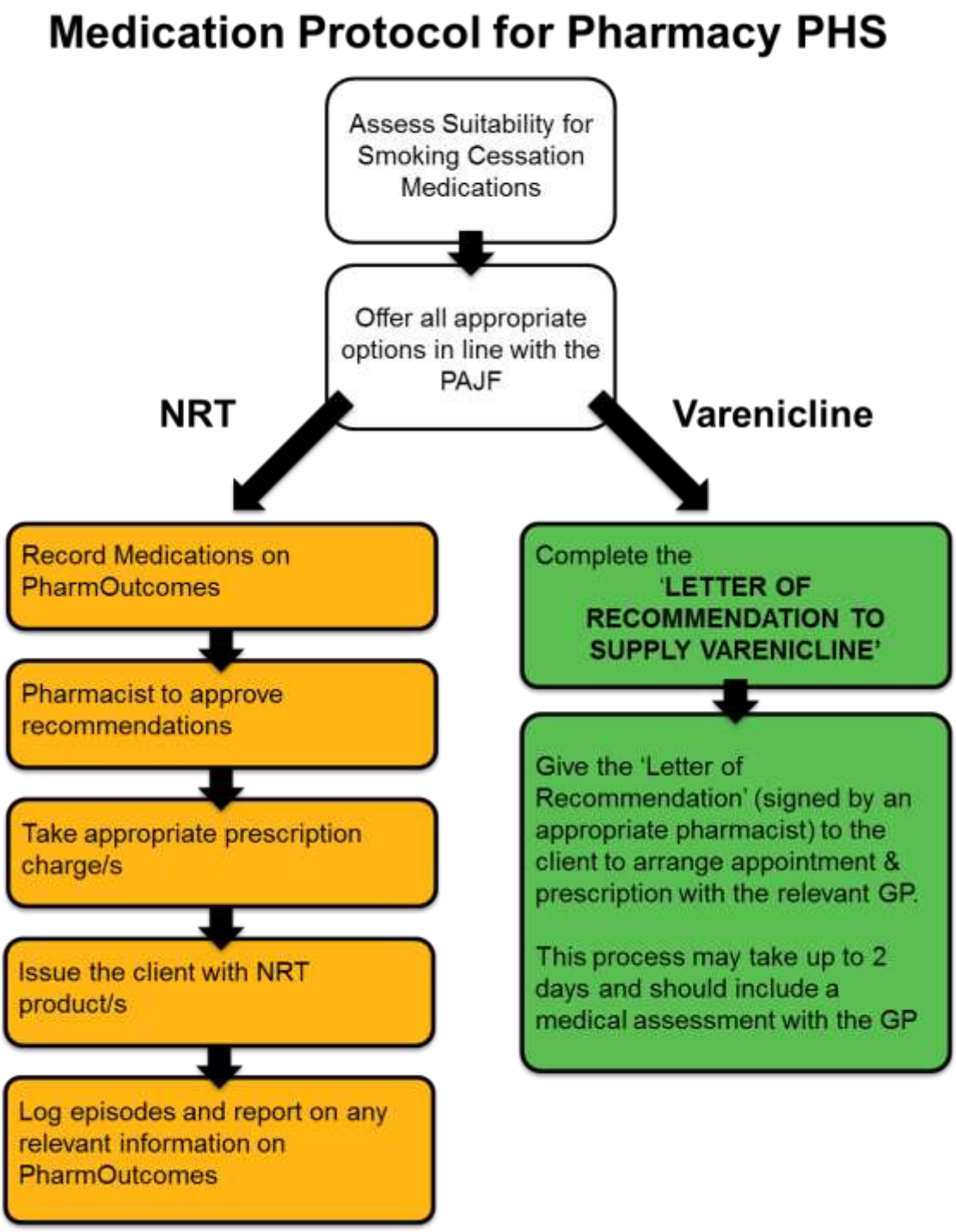
The Livewell Southwest Wellbeing Team offers a wide range of support to Community Practitioners/patients including:

- Provision of specialist clinic and groups across the city
- Provision of specialist support for pregnant women & their families
- Provision of specialist services in the regeneration areas - Devonport, Barne Barton, Stonehouse and North Prospect
- Provision of NCSCT standard training - workshop plus a whole range of training to support people to quit with differing needs.
- Provision of an annual conference to update skills and raise awareness of smoking related issues
- Provisions of in-practice brief intervention training, plus additional seminars
- Provision of CO monitors, materials and resources
- Data collection and feedback to practices
- Practice visits to support practitioners
- Telephone support to practitioners

Appendix 2 Smoking Cessation Guidelines



Appendix 3 Medication Protocol for Pharmacy PHS



Appendix 4 Pharmacy PHS LofR for Varenicline

(Example)

Date:……

PHARMACY SMOKING CESSATION SUPPORT

LETTER OF RECOMMENDATION TO SUPPLY VARENICLINE TARTRATE▼

Dear: ……

Client name: ……**Date of Birth**……..

Client address: ……..

Postcode: ……..…**NHS Number** …..……

I have discussed smoking cessation treatments with this patient at our pharmacy today. I confirm that this patient will be receiving support from myself and would therefore be grateful if you would consider prescribing the product indicated below. I have advised the client that he/she will have to have an initial appointment with their doctor in order to receive the prescription and will need a full clinical assessment.

A full treatment course should be considered following the Plymouth Area Joint Formulary. The following prescribing schedule is recommended. See Plymouth Area Joint Formulary for further details. Prescriptions should be issued in four stages, 2 weeks, 2 weeks, 4 weeks and 4 weeks. For more details on Varenicline▼ please see Varenicline▼ Summary of Product Characteristics.

PRESCRIPTION 1	PRESCRIPTION 2	PRESCRIPTION 3	PRESCRIPTION 4
2 Weeks (Initiation Pack) 25 tabs	2 Weeks (Maintenance Pack) 28 tabs	4 Weeks (Maintenance Pack) 56 tabs	4 Weeks (Maintenance Pack) 56 tabs
DAYS 1–3: 0.5mg ONCE DAILY DAYS 4-7: 0.5mg TWICE DAILY DAY 8 SHOULD BE THE QUIT DAY DAYS 8-14: 1mg TWICE DAILY	1mg TWICE DAILY	1mg TWICE DAILY	1mg TWICE DAILY

To ensure that Varenicline▼ is appropriate for this patient I have already checked the following, however we would still expect the prescriber to do a full clinical assessment for suitability.

	Yes	No	
Has the client demonstrated motivation to quit smoking?	☐	☐	
Is the patient hypersensitive to Varenicline?	☐	☐	Contra-indicated
Is the patient under 18?	☐	☐	
Is the patient pregnant or breast-feeding?	☐	☐	
Does the patient have end-stage renal disease?	☐	☐	
Does the patient have epilepsy?	☐	☐	Cautioned
Does the patient have a history of psychiatric illness?	☐	☐	

If the patient does have epilepsy or a history of psychiatric illness then a risk benefit assessment should be made by the consulting physician. NRT should also be re-considered.

If you have any queries about this patient, please do not hesitate to contact me:

Pharmacy Name	Pharmacist Name	Contact Tel No.	Signature

Appendix 5

Which medicines need dose adjustment when a patient stops smoking?

Summary

- The majority of interactions between medicines and smoking are not clinically significant.
- Healthcare professionals giving smoking cessation advice should be aware of a small number of medicines, and in particular theophylline, clozapine and olanzapine, which may require dose adjustment or increased monitoring when smoking is stopped.

Background

Cigarette smoking can interact with some medicines. This is mainly due to polycyclic aromatic hydrocarbons in cigarette smoke that stimulate cytochrome P450 enzymes, particularly CYP1A2. A number of medicines that are metabolised via CYP1A2, for example theophylline, may consequently be more rapidly metabolised in smokers. There have also been reports of pharmacodynamic interactions with some medicines.

Answer

The majority of interactions are not clinically significant but the potential for interaction should be borne in mind if a patient starts or stops smoking. The table below lists those interactions considered to be of most clinical importance, describes the nature of the interaction and advises on appropriate management when a patient taking an interacting drug stops smoking. Since the majority of interactions are due to components of cigarette smoke other than nicotine, these interactions are not expected to occur with nicotine replacement therapy (NRT). The information in the table applies to patients who stop smoking regardless of whether they use NRT or not.

The following criteria have been considered in grading the clinical relevance of interactions:

High: Documented interaction with clinically important effects in a number of patients and/or

Drugs metabolised principally by CYP1A2 and with a narrow therapeutic range.

Moderate: Documented pharmacokinetic interaction with no or minor clinical effects, or isolated reports of clinically important effects and/or

Drugs metabolised partly by CYP1A2 and with a narrow therapeutic range and/or

Drugs metabolised principally by CYP1A2 and with a wide therapeutic range.

Low: Theoretical interaction without documented cases and/or

Drugs metabolised partly by CYP1A2 and with a wide therapeutic range.

BNF category/ Drug name	Nature of interaction	Clinical relevance	Action to take when stopping smoking

BNF category/ Drug name	Nature of interaction	Clinical relevance	Action to take when stopping smoking
2.8.2 Warfarin	Warfarin is partly metabolised via CYP1A2. An interaction with smoking is not clinically relevant in most patients. The dose of warfarin is adjusted according to a patient's INR (International Normalised Ratio).	Moderate	If a patient taking warfarin stops smoking, their INR might increase so monitor the INR more closely. Advise patients to tell the physician managing their anticoagulant control that they are stopping smoking.
3.1.3 Theophylline	Theophylline is metabolised principally via CYP1A2. Smokers need higher doses of theophylline than non-smokers due to theophylline's shortened half-life and increased elimination. Some reports suggest smokers may need twice the dose of non-smokers.	High	Monitor plasma theophylline concentrations and adjust the dose of theophylline accordingly. The dose of theophylline may need to be reduced by about one quarter to one third one week after withdrawal. However, it may take several weeks for enzyme induction to dissipate. Monitor theophylline concentration periodically. Advise the patient to seek help if they develop signs of theophylline toxicity such as palpitations or nausea.
4.2.1 Chlorpromazine	Chlorpromazine is metabolised principally via CYP1A2. Smokers have lower serum levels of chlorpromazine compared with non-smokers. A case report describes a 25 year old patient with schizophrenia who experienced increased adverse effects of chlorpromazine (sedation and dizziness) and increased plasma chlorpromazine levels after abruptly stopping smoking.	Moderate	Be alert for increased adverse effects of chlorpromazine (e.g. dizziness, sedation, extra-pyramidal symptoms). If adverse effects occur, reduce the dose as necessary.
4.2.1 Clozapine	Clozapine is metabolised principally via CYP1A2 and clearance is increased in smokers. Serum clozapine levels are reduced in smokers compared with non-smokers; smokers may need higher doses. There have been case reports of adverse effects in patients taking clozapine when they have stopped smoking.	High	Monitor serum drug levels before stopping smoking and one or two weeks after stopping smoking. Be alert for increased adverse effects of clozapine. If adverse effects occur, reduce the dose as necessary.
4.2.1 Olanzapine	Olanzapine is metabolised principally via CYP1A2 and clearance is increased in smokers. Serum olanzapine levels are reduced in smokers compared with non-smokers; smokers may need higher doses. There have been case reports of adverse effects in patients taking olanzapine when they have stopped	High	Be alert for increased adverse effects of olanzapine (e.g. dizziness, sedation, hypotension). If adverse effects occur, reduce the dose as necessary.

BNF category/ Drug name	Nature of interaction	Clinical relevance	Action to take when stopping smoking
	smoking		
6.1.1 Insulin	Smoking is associated with poor glycaemic control in patients with diabetes. Smokers may require higher doses of insulin but the mechanism of any interaction is unclear.	Moderate	If a patient with insulin-dependent diabetes stops smoking, their dose of insulin may need to be reduced. Advise the patient to be alert for signs of hypoglycaemia and to test their blood glucose more frequently.

Source: North West Medicines Information Centre available at:

www.sps.nhs.uk/wp-content/uploads/2017/11/UKMI_QA_Drug-interactions-with-smoking-cigarettes_update_Nov-2017.pdf

Appendix 4 Glossary of terms

COPD

Chronic Obstructive Pulmonary Disease

CO-verified four-week quitter
A treated smoker who reports not smoking for at least days 15–28 of a quit attempt and whose Carbon monoxide (CO) reading is assessed 28 days from their quit date (-3 or +14 days) and is less than 10 ppm. The -3 or +14 day rule allows for cases where it is impossible to carry out a face-to-face follow-up at the normal four-week point (although in most cases it is expected that follow-up will be carried out at four weeks from the quit date). This means that follow-up must occur 25 to 42 days from the quit date (Russell
Standard).

CO verification should be conducted face to face and carried out in at least 85% of self-reported four-week quitters.

Commissioner
Plymouth City Council

CVD

Cardiovascular Disease

DH
Department of Health

CPPE
Centre for Pharmacy Postgraduate Education

HIP

Health Improvement Practitioner

HLP

Healthy Living Pharmacy

LoR
Letter of Recommendation (for Varenicline)

Lost to follow-up (LTFU)
A treated smoker who cannot be contacted face to face, via telephone, email, letter or text following three attempts to contact them at different times of day, at four weeks from their quit date (or within 25 to 42 days of the quit date). The four-week outcome for this client is unknown and should therefore be recorded as LTFU on the monitoring form.

NRT

Nicotine Replacement Therapy

PCC

Plymouth City Council (Commissioner)

PHS
Public Health Service

Practitioner
Stop Smoking Practitioner, employed by the Provider Lead named above

Stop smoking service provider
A stop smoking service provider is defined as a locally managed and coordinated service commissioned to provide accessible, evidence-based and cost-effective clinical services to support smokers who want to stop. Service delivery should be in accordance with the quality principles for clinical and financial management contained within this guidance.

NCSCT

National Centre for Smoking Cessation Training

Non-treated smoker
A smoker who receives no support or is given very brief advice and/or supplied with leaflets, helpline cards or pharmacotherapy only, and who does not set a quit date or consent to treatment. Examples may include smokers seen at health fairs or community events, during a GP consultation or during a hospital stay where a quit date is not set and a quit attempt is not made.

LSWWBT

Livewell South West Well Being Team

LoR

Letter of Recommendation (for Varenicline)

ODPH

Office of the Director of Public Health

Provider

Community Pharmacy providing Stop Smoking Service to clients

Quit date
The date a smoker plans to stop smoking completely with support from a stop smoking practitioner as part of an assisted quit attempt.

Renewed quit attempts
A quit attempt that takes place immediately following the end of one treatment episode.
A new treatment episode should be commenced in the database / service records.

Routine and manual smoker
A smoker whose self-reported occupational grouping is of a routine and manual (R/M) worker as defined by the National Statistics Socio-Economic Classification.137

Self-reported four-week quitter
A treated smoker who reports not smoking for at least days 15–28 of a quit attempt and is followed up 28 days from their quit date (-3 or +14 days). The -3 or +14 day rule allows for cases where it is impossible to carry out a face-to-face follow-up at the normal four-week point (although in most cases it is expected that follow-up will be carried out at four weeks from the quit date). This means that follow-up must occur 25 to 42 days from the quit date (Russell Standard).

Smoked product
Any product that contains tobacco and produces smoke is a smoked product, including cigarettes (hand-rolled or tailor-made), cigars and pipes (including waterpipes). Waterpipes include shisha, hookah, narghile and hubble-bubble pipes.

Smoker
A person who smokes a smoked product. In adulthood this is defined in terms of daily use, whereas in adolescence (i.e. for those aged 16 or under) it is defined in terms of weekly use.

Smoking cessation
In clinical terminology this is used to denote activities relating to supporting smokers to stop.

Specialist Service
Livewell South West Well Being Team

Spontaneous quitters
Smokers who have already stopped smoking when they first come to the attention of the service can only be counted as having been 'treated' and included in the national data return if they had quit 48 hours or less before attending the first session of a structured multi-session treatment plan. Where this is the case, their spontaneous quit date should be recorded as their actual quit date. Examples of such quitters include clients who experience unplanned admission to hospital and stop smoking before receiving support, those people who have started using nicotine vapourisers (as an alternative to smoking) and have not smoked for up to 48 hours, or pregnant smokers who have already stopped smoking before approaching their local stop smoking service provider. Whilst it is recognised that it is desirable to offer as many smokers as possible support to quit and maintain abstinence, local commissioners will need to balance the needs of their smoking population against available service resources. Smokers who have already stopped smoking for more than 48 hours before attending a service should not be included in the national data submission but may be counted as having been 'treated' for local accounting purposes (e.g. to justify resources used or analyse performance). It is recommended that this is only recorded if they have quit within 14 days prior to coming to the attention of the service and have attended the first session of a structured multi-session treatment plan within 14 days of their spontaneous quit date (which should be recorded as their quit date).

Stop smoking

Preferred term to denote patient-facing communications relating to smoking cessation activity.

Stop smoking practitioner
An individual who has NCSCT certification and is employed by a service which is, either directly or indirectly, commissioned to provide stop smoking support.

SWDFR

South West Devon Formulary and Referral

Time between treatment episodes
(see Treatment episode, below)
When a client has not managed to stop smoking, there is no definitive period of time required between the end of a treatment episode and the start of another. The stop smoking practitioner should use discretion and professional judgement when considering whether a client is ready to receive support to immediately attempt to stop again. If this is the case, the client must start a new treatment episode, i.e. attend one session of a structured, multi-session intervention, consent to treatment and set a quit date with a stop smoking practitioner in order to be counted as a new data entry on the quarterly return.

Treated smoker
A smoker who has received at least one session of a structured, multi-session intervention (delivered by a stop smoking practitioner) on or prior to the quit date, who consents to treatment and sets a quit date with a stop smoking practitioner. Smokers who attend a first session but do not consent to treatment or set a quit date should not be counted.

Treatment episode
At the point of attending one session of a structured, multi-session intervention, consenting to treatment and setting a quit date with a stop smoking practitioner, a client becomes a treated smoker and the treatment episode begins. The treatment episode ends when a client has been completely abstinent for at least the two weeks prior to the four-week follow-up or is lost to follow-up at the four-week point, or when a four-week follow-up reveals that a client has lapsed during the two weeks immediately prior to the follow-up and is therefore recorded as a non-quitter. Good practice dictates that if the client wishes to continue treatment after a lapse, treatment should be continued if it seems appropriate, but the client will not count as a four-week quitter for the purposes of that treatment episode.