



PCRS Pragmatic Guides for Clinicians

Diagnosis and Management of Tobacco Dependency

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In partnership with:



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PCRS

The Primary Care Respiratory Society (PCRS) is the UK-wide professional society supporting any health professional working in or with primary care to deliver high value patient-centred respiratory care.

Our vision is “**optimal respiratory health for all**” which we seek to achieve through:

- Campaigning to influence policy and set standards in respiratory medicine, relevant to populations nationally and locally.
- Educating health professionals working in primary and community settings to deliver and influence out-of-hospital respiratory care through open access to succinct best practice, evidence-based clinical guidance and resources.
- Promoting and disseminating real life respiratory research relevant to population health needs that supports policy and education activities including through our scientific journal, *npj Primary Care Respiratory Medicine*, published in conjunction with Springer Nature.
- Describing how to deliver value-based healthcare, impacting on clinical effectiveness, patient safety and a better patient experience.
- A committed and engaged membership network providing mutual support enabling professional development to support the provision and commissioning of high value, patient-centred care.

It has long been established that tobacco smoking can cause dependency; classified by the World Health Organization as substance misuse. Tackling tobacco dependency is inherent in achieving our vision of **optimal respiratory health for all** but it is more than that. One of our key priorities is to convince you that tobacco dependency is a long-term relapsing condition that starts in childhood, treating it is the responsibility of all health professionals and that there are simple and effective steps that you can take to help your patients; treating tobacco dependency should be a high priority of all clinicians.

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1.0 Context



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1.1 What is a pragmatic guide?

This pragmatic guide is a practical, immediately implementable, evidence-based framework to enable healthcare professionals to routinely identify smokers, encourage a quit attempt and support that quit attempt within the real-world context of their own professional sphere.

1.2 Who is this guide for?

This guide is relevant to any health professional working with patients or clients who wants to help their patients manage their tobacco dependence and for policy and decision makers in the health care system responsible for improved value

This is a guide for everyone working in the healthcare system including those who have direct contact with patients – prescribers and non-prescribers – and those involved in policy and decision making regarding service provision. Listing the healthcare staff who need to read this is likely to result in missing a key group, particularly as our workforce diversifies and teams broaden their skill mix. However, we want to be clear that this is everyone's job; from the Professor of Urology seeing people with bladder cancer, to the acute trust Chief Nurse managing staff sickness rates and winter pressure on beds; for the pressured GP or primary care nurse managing the complicated respiratory infections that drive busy winter surgeries and the community pharmacist who may be the only professional in contact with a smoker.

As health and social care professionals start to work in partnership in response to national policies and needs, some of the material we present could equally be delivered by social worker colleagues and reablement teams.

1.3 How this guide was developed?

An expert group of sixteen individuals with expertise in supporting smokers to quit in primary, community, acute physical and mental health settings, and in tobacco dependence research, teaching, public health and policy was convened to attend two meetings and provide evidence and opinion on treating tobacco dependence in the UK and, in particular, in primary and community settings.

This guide is the product of evidence review, debate about current practice and the environment and synthesis of messages that have been tested subsequently by stakeholders in the health system for the purposes of endorsement and dissemination. Where evidence did not exist, or was not wholly applicable, the decision-making process has been highlighted and a pragmatic solution offered.

The average annual number of visits per person to their GP surgery is now approximately six and is higher in people who smoke because tobacco smoking causes ill health; smokers are over-represented in total attendances compared to never smokers. Each of those visits is an opportunity to help that smoker quit.

1.4 Why is this pragmatic guide needed?

The prevalence of smokers making contact with health services remains high, but treatment is under utilised

The proportion of the UK adult population who smoke has diminished in recent years. However, in 2017, around 7.4 million individuals smoked cigarettes.¹ These individuals remain at risk for the short, medium and long-term consequences of tobacco dependence.

Successful interventions at an individual level by passionate healthcare professionals alongside public health interventions to reduce uptake and motivate quitting (e.g. plain cigarette packaging and a ban on smoking in indoor public spaces) have led to the decline in smoking prevalence in the UK. Healthcare providers and their commissioners must now consider a new approach to sustain and build on the good progress made by local authorities, public health interventions and legislation to reach the over 7 million individuals who continue to smoke. NHS commissioners and providers have played a pivotal role in this success by commissioning and referring smokers to specialist stop smoking services. In England, financial austerity and consequent local authority budget cuts has had an impact on public health spending with reductions in specialist stop smoking support including decommissioning or limiting of services in some areas.

Smoking creates a heavy burden for people working in health services. Adopting a different and evidence-based approach to diagnosis and treatment has been shown to reduce this

The Annual Cost of Smoking to the NHS in England

Primary care (2017):²

- 7.4 million current and 14.8 million former smokers aged ≥ 18 years
- Smoking-related burden, £1.1 billion:
 - GP visits: £794 million
 - Practice nurse visits: £111.7 million
 - Prescriptions: £144.8 million

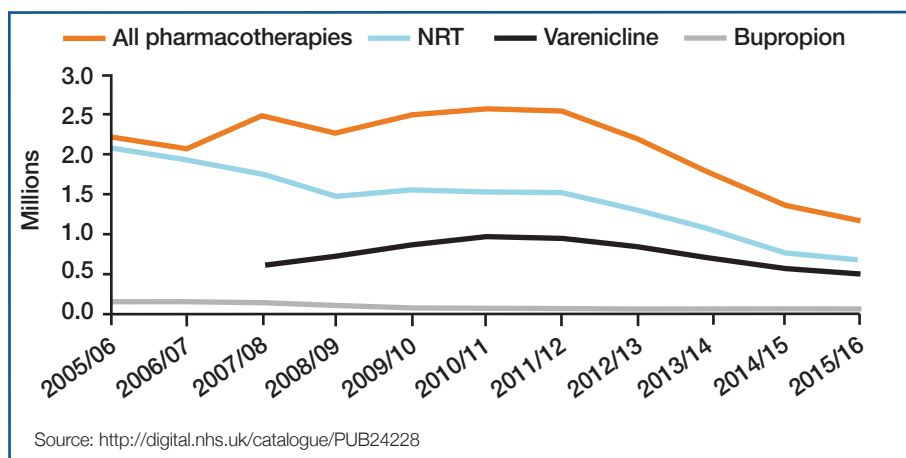
Secondary care (2018):³

- Smoking-attributable outpatient visits: £696 million
- 474,000 smoking-attributable admissions (4% of all admissions and 27% of all admissions for conditions that can be caused by smoking)
- Total cost of approximately £850 million each year

Use of NICE-recommended stop smoking interventions must be optimised if we are to continue the downward trend in smoking rates and will make an impact on numerous health outcomes

Use of prescription items to help people stop smoking in the UK has declined in recent years.⁴

ASH/CRUK stop smoking services data from 2018 suggests that 1 in 10 GPs are no longer prescribing NRT or varenicline.⁵ The recent situation analysis from the British Lung Foundation has found that prescribed levels of NRT in the community in England have declined by 75% in recent years, far exceeding the decline in smoking prevalence. In Wales, prescribing of all stop smoking treatments decreased by two thirds, and in Scotland, by 40% over two years. In England, restrictive prescribing policies in

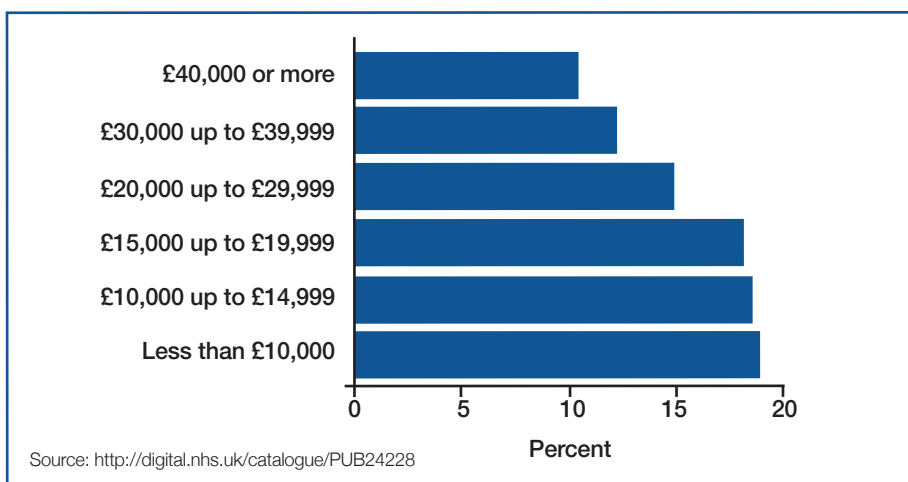


primary care are increasingly common, meaning there are areas where patients can only be prescribed either one short or one long-acting NRT. In other areas, GPs are being discouraged from prescribing all stop smoking treatments, a situation that is especially concerning in areas where there is also no specialist stop smoking services to refer patients to.

More than half of the inequality in life expectancy between social classes is now linked to higher smoking rates amongst poorer people

In the UK for the period 2015-2016, smoking rates were higher among individuals with lower average incomes.⁴

“In 2015, 11% of those earning £40,000 or more were smokers, compared to 22% of those earning less than £10,000”



Tobacco dependency increasingly exists within a population that is less well-off, has multiple health conditions and uses most health resource including high cost beds and interventions.^{6,7}

In the year of Julian Tudor-Hart's death, barriers to successful quitting still remain for those in the lowest socioeconomic groups

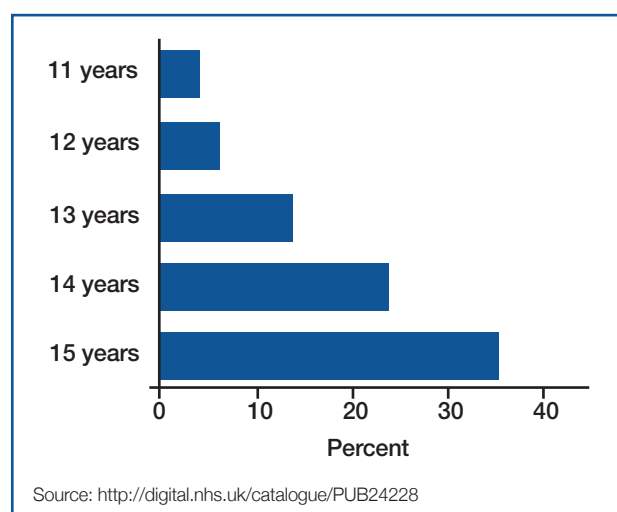
The rate of decline in smoking rates has been lowest in the more disadvantaged socioeconomic groups.⁸ These individuals are more likely to access stop smoking services but less likely than those of higher socioeconomic status to quit successfully. This is likely due to the range of additional barriers they face to quitting and maintaining a quit long term. Because tobacco dependency is commonly co-morbid with long term conditions and cancer, it is imperative for health services impact on inequality that they take action and not consider it someone else's job.

Tobacco is a major driver of health inequality experienced by people with serious mental illness

Adults with a serious mental illness have a shorter life expectancy than those without a serious mental illness. High rates of smoking among those with a serious mental illness contributes to this health inequality and yet there is good evidence that they want to quit.⁹

Tobacco dependency is a long-term relapsing condition that usually starts in childhood

We have focused in the NHS on treating the consequences of tobacco and have not considered it within the life course. **The median age that smoking starts is 13; it is a childhood addiction.**⁴ While increasing age appears to be positively associated with quitting, a proportion of those who quit will relapse.¹⁰



In the UK for the period 2015-2016, smoking prevalence increased with age of adolescents with 35% of 15-year olds reported having ever smoked.⁴

Expert group consensus

- **Treating tobacco dependency systematically and effectively will have a significant impact on the triple aim of: (1) improved individual health outcomes and quality of life; (2) equitable socioeconomic and geographical distribution of healthcare resources; and (3) improved long-term population health outcomes including reducing health inequalities.**

2.0 Management of tobacco dependency



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2.1 Instigating a quit attempt

Start with Very Brief Advice (VBA) on smoking

VBA (ASK–ADVISE–ACT) is a simple and powerful approach designed to be used opportunistically in less than 30 seconds in almost any consultation with a smoker. VBA is a public health intervention delivered in a one-to-one health setting. VBA can be delivered by any professional. VBA is high value because it is practical, cheap, quick and easy to learn. Each VBA delivered correctly can trigger a quit attempt, although it is highly unlikely that every delivery of VBA will result in a quit attempt the key to success is repeated, routine delivery of VBA to all patients.

Every VBA should include ASK-ADVISE-ACT even if the ACT is to simply record your VBA and the outcomes in the medical record so that it is immediately available to the next healthcare professional who encounters the patient. This may make it more likely the next health care professional, not only uses the VBA approach, but also builds on the previous conversation. The next encounter at which VBA is undertaken may be the one that triggers a quit attempt. It can be delivered by both prescribers and non-prescribers.

The VBA intervention is simple, but its derivation is complex and considered. It condenses significant and robust behavioural research. Language matters and its use as an intervention should be taken as seriously as prescribing a medicine. VBA deliberately does not “challenge the addict” unnecessarily as this may actually reduce the power of the advice. For example, VBA deliberately does not:

- Advise the smoker to stop
- Ask if they want to stop
- Ask details about what or how much they smoke.

This is because the offer of help in itself can trigger a quit attempt and so responses to such questions are not needed at this stage and should be left to the dedicated stop smoking consultation which will hopefully follow. Providing a positive picture of what this help looks like is also important.

Every conversation with a patient about tobacco use should start with VBA by a health practitioner who has been trained to deliver this

conversation. Tobacco VBA is a basic healthcare competency that has to be learned – it is not a chat – it is an evidence-based intervention. Many health practitioners speak with patients about tobacco, but this is not the same as the VBA method and not using an evidence-based approach to this conversation, can potentially prevent rather than encourage a quit attempt.

Using VBA does not depend on the person's readiness to quit and you do not need to assess it before you start

Clinicians sometimes worry about causing damage to the therapeutic relationship which may prevent raising the issue. Delivering evidence-based tobacco VBA takes away this concern in those who have been trained to deliver it. The question should be adapted for local patterns of tobacco use, for example in communities where smokeless tobacco use is prevalent.

It's important to consider also that smoking is a chronic relapsing condition so even when a patient has stopped smoking there is a risk of starting again. Ex-smokers should be asked about their smoking status until they have stopped for at least three years.

“If you have an understanding of tobacco dependence, then compassion follows, and you are not judgemental”

Andy McEwen,
Chief Executive,
National Centre for Smoking
Cessation and Training, 2018

Think about your own practice

At this stage write down what your current phrasing is for brief advice to smokers.

Now read the next section and/or complete the short 20-minute training online and consider what you might do differently.

ASK and record smoking status

What it is...

- Are you still smoking?
- Do you smoke at all?
- How's the stopping smoking going?



What it is not...

- Do you want to stop smoking?
- How much do you smoke?
- Why are you still smoking?
- What do you smoke?



It is important not just to ASK but to record smoking status so that if someone says they are smoking they can be given VBA when they are seen again.

ADVISE on how best to stop

What it is...

- Did you know the most effective way to stop smoking is with a combination of support and medication? Both are available on the NHS, and this combination makes you much more likely to succeed in quitting



What it is not...

- You need/have to stop smoking
- If you don't stop it will kill you!



The ADVISE part does not involve advising smokers to stop. Instead it is simply advising HOW best to stop i.e. with behavioural support and medical treatment.

ACT to signpost best available support and treatment

Your patient does not want to take action...

- OK that's fine. If you do change your mind at any time don't forget we are always ready to help you quit



Your patient does want to take action...

- That's great news! All you need to do is book an appointment with my colleague who can give you all the treatment and support you need to help you quit



The ACT part is to direct the smoker to the best available support and treatment to help them quit. Ideally this would be from a stop smoking service or trained stop smoking advisor. If this is not available locally you can recommend that they make a dedicated appointment with yourself or an appropriate member of the practice team. You or they can then go through treatment options provide prescriptions and help support them with a few appointments while they quit.

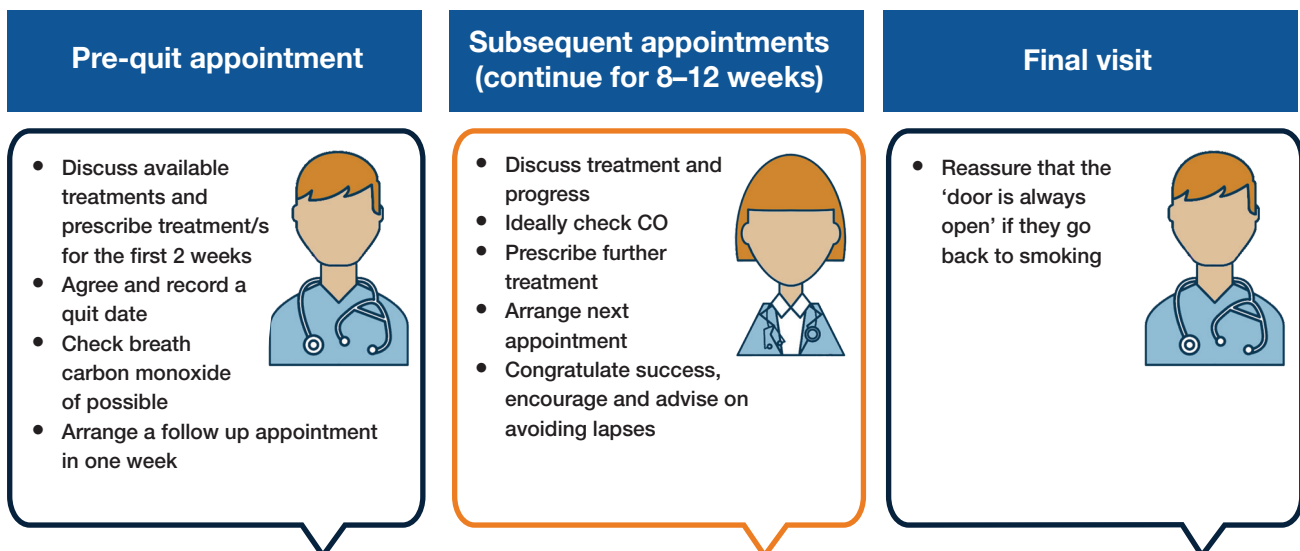
The above describes basic VBA which is designed for opportunistic delivery to any smoker in less than 30 seconds during any clinical encounter. This is the minimum which should be delivered as part of routine practice. Depending on the patient, time available and clinical circumstances, VBA can be modified and extended as necessary to improve the chance of the smoker engaging in a supported quit attempt. Case examples are given in section 2.3.

Link to VBA resources:

- **Short, online training in Very Brief Advice of smoking:**
http://elearning.ncsct.co.uk/vba-stage_1

2.2 Supporting a quit attempt

Completing the VBA will tell you your patient's self-reported tobacco status – an important first step. VBA is our most practical tool to trigger a quit attempt, with structured behavioural support and medical treatment being the best method of quitting and ideally these are provided by stop smoking practitioners. If smokers are unwilling or unable to attend specialist stop smoking services to quit smoking support can be effectively offered by GPs within a series of standard 10-minute appointments. In September 2018, the Royal College of General Practitioners (RCGP) issued practical guidance on the delivery of smoking cessation support by GPs consisting of a pre-quit appointment, subsequent weekly, biweekly then monthly appointments over 2 to 3 months and a final visit. This guidance is available as an online course via the RCGP elearning portal at <http://elearning.rcgp.org.uk/> (course name: Essentials of smoking cessation). The core components of the guidance are summarised below:



As a clinician you will also be treating people for conditions where management of tobacco dependency is part of the therapy pathway and because the impact of continued use is so serious. You may therefore need to gather more information to help co-create a plan with your patient or indeed find yourself holding information that needs further discussion.

For example

- Women booking pregnancy in England are expected to have an exhaled carbon monoxide recording by a relevant healthcare professional regardless of reported smoking status.¹¹
- A joint colleges recommendation led by RCPsych recommends people with severe mental illness have an exhaled CO check at their annual physical review and that smoking is considered at each interaction with the health system.

Box A provides an overview of ways to assess tobacco use in more detail. You may also need to evaluate a patient's level of tobacco dependency in order to determine whether an individual may need more intensive interventions to support their quit attempt and this is considered in Box B.

Box A: Assessment of tobacco use

The best way of determining smoking status is to ask people: "Do you smoke?".

The exhaled carbon monoxide (CO) test¹² detects exposure to CO in the last 12-18 hours. This can be used to assess smoking status AFTER a quit attempt and used prior to a quit attempt as a motivational tool. Higher levels (parts per million) equate with greater inhalation of tobacco smoke assuming the cause is tobacco smoking. It must be noted that the exhaled CO test indicates recent exposure to CO and will not indicate smokeless tobacco use and is not a measure of dependency. In pregnancy, a CO of 3 ppm has been proposed as an appropriate cut-off for referral to stop smoking services.

The cotinine test¹³ is more specific for nicotine exposure and may be useful in the context of infrequent waterpipe use or smokeless tobacco use and can also be collected via a urine sample in the case of children who may be exposed to environmental tobacco smoke. It is not useful for people who use NRT or e-cigarettes and is a laboratory-based test.

Pack years¹⁴ provides a measure of exposure; this calculator also allows the evaluation of cigars, roll-up cigarettes, pipes, tobacco by weight and water pipe use and converts them to pack-year equivalents).

Number of years a person has smoked

Box B: How can I and do I need to determine my patient's level of dependency?

All smokers will benefit from support to quit smoking. The Expert Group advocate that it is important for clinicians to be able to identify those likely to need more intensive interventions to quit. Ways to evaluate level of dependency and indicators suggesting patients may need more intensive support include:

- More dependent smokers: Heaviness of Smoking Index (HSI)¹⁵ provides a score for nicotine dependency:

Question 1: On the days that you smoke, how soon after you wake up do you have your first cigarette?

- A. Within 5 minutes (3 points)
- B. 6–30 minutes (2 points)
- C. 31–60 minutes (1 point)
- D. After 60 minutes (0 points)

Question 2: How many cigarettes do you typically smoke per day?

- A. 10 or fewer (0 points)
- B. 11–20 (1 point)
- C. 21–30 (2 points)
- D. 31 or more (3 points)

A patient will have an HSI score of between 0 and 6 with a higher number indicating heavier dependence and thus a need for more intensive behavioural support and treatment. The patient can be informed of this.

- For time-pressured clinical environments, the one question that is most helpful in determining a high nicotine addiction is: **How soon after waking do you smoke your first cigarette (use tobacco)**. The sooner the time to first use of tobacco after waking the greater the nicotine addiction. This will impact on the level of treatment and support that you need to recommend to the patient.
- People with severe mental illness
- Those who continue to use tobacco whilst experiencing a severe, life-shortening, disabling or frightening co-morbid problem such as COPD or throat cancer
- Pregnant women¹⁶

A variety of interventions and support services have been shown to enhance the chances of achieving a successful quit. The National Institute for Care Excellence (NICE) has described those interventions at person, organisation and system level that have a clinical and cost effectiveness evidence base.¹⁷ Behavioural support combined with either pharmacotherapy (varenicline) or NRT (combination of long-acting and short-acting therapies) are likely to be the most effective approach to support a quit attempt.¹⁷

NICE recommended stop smoking interventions (as of March 2018)¹⁷

Evidence-based intervention	Details
Behavioural support	Individual or group face-to-face session with a counsellor trained in smoking cessation. Usually combined with pharmacotherapy
Pharmacotherapy with varenicline (oral tablet) ^a	<p>12–24-week course (usually started 1–2 weeks before target stop date)</p> <ul style="list-style-type: none"> • Initial dose: 500 micrograms for 3 days • Then: 500 micrograms twice daily for 4 days • Then: 1 mg twice daily for 11 weeks <p>Effectiveness improved when used in combination with behavioural support</p>
Pharmacotherapy with nicotine replacement therapy (NRT)	<p>NRT products licensed for smoking cessation in the UK include:</p> <ul style="list-style-type: none"> • Dermal patch • Gum • Lozenge • Mini lozenge • Sublingual tablet • Inhalator • Nasal spray • Oral spray • Oral film <p>Combination of two or more forms of NRT (ideally a long-acting combined with a short-acting form) is routinely recommended</p> <p>All forms of NRT are prescribable and OTC NRT has been shown to have relatively poor efficacy</p> <p>Effectiveness improved when used in combination with behavioural support</p>
Pharmacotherapy with bupropion (oral tablet) ^a	<p>Adults (usually started 1–2 weeks before target stop date):</p> <ul style="list-style-type: none"> • Initial dose: 150 mg for 6 days • Then: 150 mg twice daily for 7–9 weeks • Discontinue if abstinence not achieved at 7 weeks <p>Elderly: As above but maximum daily dose of 150 mg per day</p> <p>Effectiveness improved when used in combination with behavioural support</p>
e-Cigarettes	Nicotine containing e-cigarettes have been shown to be effective for smoking cessation but none are currently available with a license

^a Refer to the product information in the British National Formulary for specific information on dosing, drug interactions and side effects;
NRT, nicotine replacement therapy; OTC, over-the-counter

Diagnosis and Management of Tobacco Dependency

The Expert Group considered and ranked the strength of clinical evidence and the clinical utility of each intervention recommended by current NICE guidance.

The evidence and usability of the interventions			
Intervention	Strength of evidence ^a	Improvement in success rates when used appropriately ^b	Ranked recommendations
Pharmacotherapy plus specialist behavioural support	A	200–300%	A
Pharmacotherapy with HCP endorsement	B	50–100%	B
Behavioural support from a trained stop smoking practitioner	B	Unknown	B
Quitting with the help of e-cigarettes	C	Unknown	C
NRT obtained OTC	D	Unknown	E
Unassisted quit	E	Unknown	E
^a A defines strongest supporting clinical evidence and E defines the weakest supporting clinical evidence ^b Assessment of improved success rates compiled by Professor Robert West based on combined evidence from peer reviewed publications and NICE Guidance HCP, healthcare professional; NRT, nicotine replacement therapy; OTC, over-the-counter			

Other services that may be available to support a quit attempt in addition to support plus pharmacotherapy or combined long- and short-acting NRT include text messaging services, internet-based smoking cessation services and smart phone apps.¹⁸ This multi-component approach may be especially useful for economically disadvantaged smokers.¹⁸

The **“Not One Puff”** rule is an essential part of any intervention to support a quit attempt. An engaged and supportive HCP eliciting a “strong” promise from a patient that they will not take one puff does not take long to do but has proven effectiveness in delivering a quit. The withdrawal symptoms and urges to smoke will not diminish if people smoke after their quit date and will seriously hamper a patient’s chances of achieving abstinence.

Think about your own practice

Explore the services and support available in your own area for patients wishing to stop smoking.

Is there a dedicated stop smoking service to which you can refer patients?

Are there specialist pharmacy services in your local area with expertise in advising patients on OTC NRT?

If you are a prescriber, are there any formulary guidelines you must adhere to?

If you are not a prescriber, where should you refer or direct a patient who wishes to receive pharmacotherapy to support their quit attempt?

2.3 Exploring treatment choices for different smoker types

We identified a number of characteristics of smokers who present to healthcare practitioners, that we have clustered here into smoker types that you may recognise. These are not real cases and are not presented in any specific order. The purpose is to illustrate how the post-VBA process can be tailored.

Smoker type 1: Male 33 years old, attending for back pain

Bogdan is a 33-year-old man. He is a manager at a small company selling car parts. He is attending your clinic with back pain after lifting heavy boxes at work. You identify his pain as muscular, advise on appropriate physical activity, weight management and OTC NSAID analgesics. You have not seen Bogdan for several years. You decide to implement VBA on smoking

ASK: “Do you smoke?” Yes, but I know I shouldn’t

ADVISE: “Did you know that the best way to quit is with medication and support? We have a local, friendly stop smoking service I can refer you to, many of my patients have found it useful” Thanks but I think I’ll try by myself first, maybe with chewing gum

ACT: Ask Bogdan what he thinks the stop smoking service entails and provide additional positive information. Prescribe nicotine gum and offer a revisit. Record in Bogdan’s notes that VBA was performed and his intent to attempt a quit

Key resources:

- <https://www.nice.org.uk/guidance/ng92/>
- http://elearning.ncsct.co.uk/vba-stage_1

Expert commentary:

Bogdan’s visit illustrates the value of implementing **VBA** regarding smoking for patients regardless of their reason for attending. At this time Bogdan has opted to try and quit without additional stop smoking services or support. He also now knows that there are interventions and support services available to him if he doesn’t succeed and that support can add to the success of treatment. Your **VBA** has prompted a potential quit attempt and opened an ongoing dialogue with Bogdan for you to implement a **VBA** at his next clinic visit. After hearing his response, exploration of reasons for not using a service or motivational interviewing could have been implemented here to encourage Bogdan to more carefully consider his decision given that pharmacotherapy combined with behavioural support would provide him with the best chance of a successful quit.

A proportion of quit attempts instigated by **brief advice** will succeed without further healthcare support.^{19,20} Your **ADVISE** will always be to suggest the best supported quit available. Even if nothing else is done by the health sector or the health sector has not commissioned the ‘best practice’ in your area, your **VBA** will still be worthwhile. In the absence of local specialist stop smoking services, your **ADVISE** may be to recommend a follow-up visit and pharmacotherapy as the next most effective intervention. In a large study across the whole of England, it was found that smokers were almost twice as likely to try to stop if they had been offered help by their GP than if they had only been advised to stop. The importance of recommending both support and treatment in the **VBA** is highlighted by a study which showed that compared with no advice to smokers, the odds of quitting are 68% higher if stop smoking medication is offered and 217% higher with offer of support.²¹ As an alternative, the next most effective option may be support along with ‘triple therapy’ consisting of varenicline and NRT with both a long-acting (e.g nicotine patch) and a short-acting product (e.g nicotine gum).

Smoker type 2: Pregnant and children at home

Karen is a 32-year-old mother of two and is currently 6 months pregnant with her third child. She has presented to you with a candida infection but is otherwise well. You examine her and prescribe a topical antifungal. She has also brought her oldest son, Sam, to see you. Sam is 5 years old and has been wheezy with a dry cough in the mornings for the last couple of weeks. You examine Sam and hear occasional bilateral wheeze with a normal respiratory rate, pulse, sats and temperature. You suspect asthma and start to make a plan with Karen for Sam. You have cared for Karen during her previous pregnancies and are aware that she has asthma, a history of smoking and that her partner smokes. She has made several attempts to quit in the past using OTC nicotine replacement, but she has not so far been able to sustain a quit. You see in Karen's notes that her midwife implemented a VBA when she booked Karen in. You decide to implement a VBA

ASK: "Are you and your partner smoking at the moment Karen?" Yes, I spoke with the midwife when she booked me in and she said she was concerned and referred me but I have so much to deal with at the moment I just don't think I can do it on my own. I've cut down loads and we only smoke outside now

ADVISE: "So, you've tried nicotine replacement before and didn't succeed. Don't worry though because we know that the best way to quit is combining the NRT with support and we have 7 different forms that are appropriate in pregnancy. "We have a stop smoking service I can refer you to, many of our pregnant women have found it useful.

ACT: "Would you like me to let them know ?" Yes please, I know I should stop

Record in Karen's notes that VBA was performed, and make a referral to the smoking in pregnancy specialist stop smoking service

Key resources:

- <https://www.nice.org.uk/guidance/ph26>
- VBA on smoking for pregnant women: http://elearning.ncsct.co.uk/vba_pregnancy-launch
- VBA on second-hand smoke: http://elearning.ncsct.co.uk/shs_vba-launch
- Midwifery guidance: http://www.ncsct.co.uk/publication_briefing_for_midwifery_staff.php

Expert commentary:

In accordance with NICE guidelines, Karen's midwife performed a **VBA, CO screening, raised her concerns and made a referral to a specialist service** because of the CO test result reading of 16ppm at her booking in consultation. Karen also learned about the effect smoking could have on her baby and her other children. Revisiting the **VBA** and her CO results has prompted a quit attempt highlighting the value of repeated **VBA** and a consistent messaging from all the HCPs that Karen encounters. As Karen's partner also smokes, an offer of referral for them should also be made. Encouraging pregnant women to attend with partners can enable such discussions. Active referral on an opt out basis (as shown here) is appropriate and evidence based for pregnant women. But this is not the norm for **VBA** where smokers are encouraged to book their own appointments for support and treatment so that they "own the attempt" and increase self-efficacy. The DH Tobacco Control Plan aims to reduce the rates of smoking in pregnancy to 6% or less by 2022. The Smoking in Pregnancy Challenge Group (coordinated by ASH), estimates that if the target were to be achieved it would lead to an annual reduction of between:

- 45 – 73 fewer babies stillborn
- 11 – 25 fewer neonatal deaths
- 7 – 11 fewer sudden infant deaths
- 482 – 796 fewer preterm babies and
- 1455 – 2407 fewer babies born at a low birth weight.

Smoker type 3: Serious mental illness with attendance at in-patient service

Adam is 25 years old and has bipolar disorder for which he has been hospitalised previously. He has come to see you for a routine check because you as his GP have taken over prescribing of his mood stabiliser medication. He indicates his symptoms are under control and that he has had mild nausea and some tiredness but is happy to continue taking his medication. From his notes you see he has been a smoker since the age of 15. You decide to implement a VBA regarding smoking

ASK: “Are you smoking at the moment Adam?” Yes, it keeps me calm and hopefully will stop me gaining weight on these meds. I’m OK right now and anyway I’m going to start using e-cigarettes and maybe quit like that.

ADVISE: Great, I know a lot of people have found this a useful route to quitting. Have you got an e-cigarette yet? e-cigarettes can help people stop smoking but remember that there are a range of medications which can really help too and no matter what you use, support from a stop smoking advisor will improve your chances significantly”

Your ADVISE may also include informing Adam that support plus pharmacotherapy with varenicline or support plus ‘triple therapy’ consisting of a long-acting NRT (e.g nicotine patch) in addition to his e-cigarette may be more effective in helping him quit than his e-cigarette alone.

ACT: “Would you like to see an advisor who can help you?” No thanks, I’ll be OK with the vapes

Record in Adam’s notes that VBA was delivered, and that Adam intends to make a quit attempt using e-cigarettes. Prescribe varenicline or a long-acting NRT (for use alongside Adam’s chosen short-acting NRT, the e-cigarette) depending on Adams preference and tell him that support is always available. Schedule a follow-up visit to continue support or repeat the VBA.

Key resources:

- <https://www.nice.org.uk/guidance/cg90>
- <https://www.nice.org.uk/guidance/ph48>
- http://www.ncsct.co.uk/publication_mental_health_briefing.php

Expert commentary:

Smoking rates are significantly higher among individuals with mental health conditions than among the general population. In England, the prevalence of smoking among adults with a serious mental illness is estimated at 27.8% for 2017/18 and 25.8% for adults with anxiety or depression.²² VBA should be a routine part of consultations with patients with chronic mental health disorders.

Adam has indicated that he intends to attempt a quit using **nicotine** via e-cigarettes. According to PHE, e-cigarettes, although not risk free are substantially less harmful to health than smoking. He should be advised that his chances of stopping will be improved if he gets behavioural support whether he uses the established medications or e-cigarettes. Many patients who use e-cigarettes continue to smoke at least some cigarettes so all should be advised to stop smoking combustible tobacco completely to avoid continued harm.

If Adam does choose to use a stop smoking service, he should expect support which incorporates his e-cigarette use. He should be offered support plus pharmacotherapy (varenicline which is as safe in people with stable bipolar disorder and schizophrenia as in the general population,) or support plus ‘triple therapy’ consisting of varenicline along with both a long-acting NRT (e.g. a nicotine patch) and his short-acting NRT e-cigarette.

The Royal College of Psychiatrists (RCPsych) issued a position statement in December 2018 supporting the prescription of varenicline when clinically indicated to support patients with severe mental illness to stop smoking.²³ With regard to e-cigarettes, the RCPsych believe that patients should be advised that e-cigarettes may help them quit, especially when used alongside other smoking cessation treatments.²³

Smoker type 4: 56-year-old manual worker– attended urology clinic with urinary symptoms and blood in urine

Mohammed is a 56-year-old father of four originally from the middle East. He is attending a urology clinic with haematuria. He knows that he has been referred to exclude bladder or kidney cancer. He has been given the all clear and will be discharged. You note from the GP 2-week referral letter that Mohammed is a current smoker. You decide to implement a VBA regarding smoking

ASK: “Mohammed, I see from your GP notes that you use tobacco?” Mainly in a waterpipe. I don’t smoke cigarettes as much these days

ADVISE: “Waterpipes carry significant health risks as well as the few cigarettes that you’re smoking. The best way to quit is with medication and support. We have a stop smoking service I can recommend, many of my patients have found it useful” Yes, I’d like that – this bleeding has made me realise I have had a lucky escape

ACT: Record in Mohammed’s notes that **VBA** was performed, and a self-referral recommended to a **stop smoking service**. Record in the discharge letter so his GP surgery can follow up with VBA

Key resources:

- <https://www.nice.org.uk/guidance/ng92/>
- <https://www.nice.org.uk/guidance/ph39>
- <https://bnf.nice.org.uk/drug/varenicline.html>

Expert commentary:

Although data are not routinely collected in the UK, waterpipe use does appear to have increased in recent years. Many users regard it as safer than smoking. However, waterpipe ingredients and other smokeless tobacco products contain a large number of known carcinogens and have been shown to induce nicotine dependence. In addition, chewed tobacco products have been particularly associated with oral and pancreatic cancers while waterpipe use has been associated with respiratory diseases and lung cancer.²⁴ Mohammed readily agreed to make a quit attempt with pharmacotherapy and behavioural support as episodes when people make contact with hospitals are often teachable moments because serious disease is more likely to be an issue. He may require specialist support from a counsellor with expertise in the use of waterpipes or other smokeless tobacco products

Smoker type 5: 52-year-old woman, recently had a 24-hour admission with 'chest pain' diagnosed as acid reflux

Nancy is a 52-year-old woman. She was recently admitted to hospital with chest pain that was diagnosed as acid reflux. She has been prescribed a PPI and has come to clinic to talk through her diagnosis with you. She has type 2 diabetes mellitus that is well controlled with diet and an oral antidiabetic agent; she has a BMI of 37. Nancy works as a personal assistant to an executive in a large financial company. Her 72-year-old husband died suddenly 12 months ago. Nancy has been a smoker since her early 20s and has indicated at previous visits that since her husband's death she wants to quit but has not felt ready. You decide to implement a VBA

ASK: "Are you still smoking Nancy?" Yes, but I think I might be ready to at least try and quit

ADVISE: "That's great. The best way to quit is with medication and support through our stop smoking service which many of my patients have found useful" **Can I just take the pill?** "You can, but the support you will get from the stop smoking service will improve the likelihood of you being able to quit and quit for good"

ACT: Ideally Nancy will be willing to go to the stop smoking service who can help her. If not, it is best to ask her to come back for a dedicated stop smoking appointment with you or someone else in the practice to go through all the treatment options, give her a prescription and follow her up while she tries to quit. At this next visit all the available treatments should be discussed, CO should be checked if possible, any prescriptions should be given and be of sufficient duration until the next scheduled visit. Ideally, there should be between 2 and 4 further follow-up visits over 2–3 months to provide support, encouragement and congratulations on success, check breath CO and prescribe further treatment. A final visit should also be planned for and arranged at which you can reassure that patient that the door is always open if they do go back to smoking and that they are welcome to come back for your help at any time. Nancy is quite highly dependent having smoked for around 39 years, currently smoking around 15 cigarettes each day with her first cigarette shortly after she wakes. She is likely to need significant support, as well as a choice from the full range of treatments. This can not be done properly as part of a review appointment for her reflux and she needs a dedicated appointment about stopping smoking. Record in Nancy's notes that **VBA** was performed, and a referral made to a **stop smoking service or to come back to discuss cessation properly**. Schedule a follow-up visit

Key resources:

- <http://www.ncsct.co.uk/usr/pub/NCSTP%20STP.pdf>
- <https://www.nice.org.uk/guidance/ng92/>
- <https://bnf.nice.org.uk/drug/varenicline.html>
- <https://www.theipcr.org/display/TreatP/Video+clips+and+link+to+Vimeo+channel>

Expert commentary:

Tobacco dependence is one of the most prevalent long-term conditions as measured by the UK GP Quality and Outcomes Framework (QOF) registers in 2017 at **15.1%** in comparison to hypertension **13.9%** and **Diabetes Mellitus 5.4%**.²⁵ Performing a **VBA** for smoking for all patients with chronic health conditions has the potential to instigate quit attempts in those most likely to benefit from stopping smoking. Nancy, while accepting **pharmacotherapy** to help with her quit attempt, was less accepting of **behavioural support**. Nancy's high BMI along with the other indicators of high dependence warrant a concerted effort to support Nancy to move to a more effective intervention with the addition of behavioural support.

How should I classify and code tobacco dependency?

International guidance classifies smoking as a substance misuse disorder that warrants treatment. This supports the view of the Expert Group that it is a responsibility of health services to research and produce guidelines, treatments and pathways to ensure that treatments are effective and accessible. However, the Expert Group were concerned that these definitions perpetuate an understanding of tobacco dependence only being a problem once other disease is co-morbid. The expert group regards tobacco dependency as a long-term relapsing-remitting condition that usually starts in childhood.

Expert group consensus

- **Smoking is a substance misuse disorder that warrants treatment**
- **Tobacco dependency is a long-term relapsing-remitting condition that usually starts in childhood**
- **It is a responsibility of health services to research and implement best-practice guidelines, treatments and pathways to ensure that treatments are effective and accessible**

3.0 Difficult clinical questions, conversations and responses – The expert panel responds



Q: My patient smokes cigarettes and has a BMI of 43, they drink 45 units of alcohol a week and their physical activity is limited. What should I do first or is it better to tackle all together?

A: Deal with their presenting issue first. Express concern about weight, alcohol use and smoking: “I am concerned about...and there is something we can do”. Be hopeful and supportive. Deliver VBA for alcohol and smoking and ask the patient what they want to address first – there is evidence that sequential intervention has better outcomes. This works for most people most of the time.

Q: Won't people get tired and annoyed of me doing VBA on them?

A: The value of VBA given correctly and with empathy is positive, non-confrontational, engaging and quick. If you understand they have a dependency, you will act with compassion. People get tired of being told to stop smoking, this is not VBA.

In any given year, about 30% of smokers are thinking of making a quit attempt and about half are attempting to cut down. Keep on delivering VBA and you stand a chance of catching a patient who is receptive to your offer of help. Smokers expect to be asked about their smoking by healthcare professionals.

Q: My patients just don't want to stop, what should I do?

A: In fact, most smokers DO want to stop but often feel unable; they know they should stop but don't know how. This is why VBA is designed to give advice on the best way to quit without telling them to stop. Whenever you encounter a smoker, you should offer them help and hope. Quitting is a process not an event, even a failed quit attempt matters and is a part of the process towards a successful and permanent quit. The motivation to stop smoking can vary even on a daily basis.

This is why VBA needs to be repeated as you never know which time you give it will trigger the successful quit.

Q: My patient also smokes marijuana, will VBA work?

A: Your patient's cannabis use will have to be directly addressed if they decide to quit smoking.

Advise the patient that if they smoke cannabis with tobacco this still counts as 'smoking' and this continued consumption of tobacco will seriously harm their chances of quitting. Advise to cut out cannabis, at least in the short term, and then you can discuss other methods of using cannabis that do not involve tobacco. The best current evidence for cannabis cessation is with CBT though studies are rather limited.

Q: How does VBA differ from motivational interviewing?

A: As its name implies, VBA is very brief and does not require any assessment of readiness to quit or exclude those who say they are not ready. Therefore, it includes everyone, every time. Its use will alter the readiness – the motivation – of some and is therefore closer to a universally accessible intervention. Motivational interviewing requires more intensive training for effective delivery. The NCSCT has an online training module for VBA which can be accessed at <https://elearning.ncsct.co.uk/england>, training should always be completed before delivering VBA or MI.

Q: Is everyone who smokes dependent on tobacco? What about social smokers?

A: No, but this doesn't make it safe. Harmful tobacco use is that represented by a shift from 0 to 1 cigarettes. The risk of smoking is not linear. The risk of one cigarette per day has been shown to be half that of 20 per day.

Q: I support people to quit and prescribe accordingly but when delivering a COPD update recently was astonished to discover that they have been told that they must not prescribe anything for smoking cessation. I believe this to be the most unethical thing I've heard for some time. If I worked locally I'd ignore it but

how do we empower clinicians to challenge dictats such as this in the interests of patient focused care?

A: In England, this situation has arisen in some areas because the budget for providing smoking cessation products has been diverted to other parts of the healthcare services system. We, as an expert group, believe that behavioural support + pharmacotherapy for smoking cessation is fundamental to helping people to stop. The funding should be provided where treatment is delivered. The medications used for smoking cessation support are available and can be prescribed by GPs as independent prescribers and any other clinician prescribers, just as you would prescribe treatment for any other long-term conditions such as diabetes or hypertension. Irrespective of local guidance, pharmacotherapy should be prescribed where clinically indicated.

Q: How do we best advise a patient who wishes to buy an electronic cigarette? What pointers should they look for and are they all the same with regards to safety profile? It's all very well saying they need to be 'approved' but how does a patient know what to look for? Is the 'pound shop' ok or a 'vape shop' or the market?

A: As an expert group we are not currently in a position to make any recommendations about individual products. All Vape products in the UK should be registered under the TPD (Tobacco Product Directive); 94% of current commercially available devices are registered. ASH guidance is to seek out a specialist Vape shop and discuss your needs with them. Many local stop smoking services are also e-cigarette friendly and they will be prepared to discuss these issues with your patient.

Useful resources:

http://elearning.ncsct.co.uk/e_cigarettes-launch

https://www.youtube.com/playlist?list=PLvBx3_9F8cFmB6Y_pWsawuQhdy-x_1i4K

http://www.ncsct.co.uk/publication_electronic_cigarette_briefing.php

Q: Seeing a patient in the urgent care appointment system in a GP surgery who currently smokes and (1) is attending with a respiratory infection (no respiratory long term condition), (2) a flare up of their respiratory condition or (3) is a smoking parent of child experiencing either 1 or 2. Do you - in addition to VBA at this moment - routinely recommend as part of their self- management /treatment plan to swap tobacco to NRT or electronic cigarette in order to reduce short term risks/harm

A: Always start with VBA. If the response to VBA is positive you should seek to engage the patient in a quit attempt. NRT is helpful for managing withdrawal symptoms with a view to quitting. For parents – direct to ROSPA guidance (don't smoke in the house, use Vape). If a patient is considering using e-cigs, make sure they know all other options available to them and reinforce that the aim should be to quit

Q: Please can you give us some motivational lines for our patients with COPD who do not want to stop. We often hear the same resistance, for example, 'I've been smoking for too long to stop now' or 'I've tried many times before and I can't do it'. We are perfectly placed to encourage and support these patients to stop and yet can have very little success so any advice on motivational interviewing to encourage health behaviour change would be great

A: Start with VBA. When you Advise emphasise that there are quick ways that can help and support rather than reiterating familiar messages on the damage smoking does. Explore the patient's knowledge and agenda and build your approach on their responses. The value of empathy and you believing, and communicating your belief, that stopping smoking is achievable cannot be overstated.

Specific motivational lines that may be useful include having recognised that many patients with COPD judge themselves harshly and when they say they have 'tried many times before and can't do it' they have in fact been successful in stopping for a period of time and then relapsed, so exploring this using open-ended questions e.g. 'tell me

about how you stopped smoking for xx days/weeks/ months when you quit before' and using reflection e.g. 'it sounds like smoking has been a really important part of your life', using affirmation for any previous successes. e.g. 'that is very impressive that you were able to stop previously for xx time'.

Empathy can be used to communicate that you know how challenging this is e.g. 'we know this is such a hard thing to do especially when smoking has been part of your life since you were e.g. 13 years old' and providing information can be combined with communicating optimism on how we now treat tobacco dependence e.g. 'we now talk about 'smoking' as a relapsing, remitting long-term condition that we treat as tobacco addiction. We also know that we now have treatments that work, and have worked for many of our patients, where like you, on the one hand they know smoking is making their breathing worse and on the other hand smoking has continued to be an important part of their lives, who have been able to stop smoking and remain over time 'ex-smokers'.

Q: The main issue we have with patients, is encouraging those that say to us "What's the point in giving up now? I'm unwell already, so I might as well carry on. It's the only thing I love to do, if I haven't got smoking, I have nothing." "When I try to stop smoking my chest feels worse, I bring up more phlegm and now I'm putting on weight which is making my breathlessness worse." "The only thing that brings my phlegm up, is having a cigarette. It's better than those exercises you showed me!" How do we encourage these patients to stop?

A: It is always appropriate to be positive about stopping smoking as there is good evidence that individuals who stop smoking will achieve health benefits regardless of their overall health and comorbid conditions. It is likely that some people will notice more phlegm (the body is surprised that there isn't smoke going in – and is used to producing more phlegm to try to protect itself from the damage – this can take some months to settle).

Q: Latest guidance says e-cigarettes are 95% less harmful than smoking. How best for me as a GP to communicate this to patients? How best can our nurses support patients wanting to quit using e-cigarettes?

A: There is no combustion (burning) with e-cigarettes and this is the main reason that they are so much less harmful than smoking. Ask your nurses to take the NCSCT e-cigarette course and to read the NCSCT briefing. Your patients can view The Switch suite of films (<https://www.youtube.com/watch?v=GPxxBvf6hJU&feature=youtu.be>).

Q: Is it worth getting an exhaled carbon monoxide monitor?

A: Yes. It can be a powerful motivational tool.

Q: When and for who should I consider prescribing varenicline?

A: Anyone who wants it and for whom it is not contraindicated.

Useful resource:

<http://www.london senate.nhs.uk/wp-content/uploads/2015/04/Why-and-how-to-prescribe-varenicline-in-hospital.pdf>

Q: I'm a community pharmacist who up until a year ago offered stop smoking support. This service was decommissioned in my local area. What can I do to help my patients to stop?

A: You can continue to deliver VBA which can routinely be delivered with OTC requests for cough mixtures, medicine use reviews or when prescriptions arrive for patients with long-term medical conditions.

VBA can also be delivered when a patient requests OTC NRT. In this setting it is important to emphasise that a combination of long- and short-acting NRT with behavioural support has been shown to be considerably more effective than NRT alone. It would also be important to explain that a combination of varenicline and behavioural support is likely to be the most effective approach.¹⁷ If your patient prefers NRT, then a combination of a long-acting product (e.g. a nicotine patch) provides background nicotine throughout the day (and night if needed) and a short-acting product (e.g. nicotine gum) can be used for breakthrough cravings.¹⁷

4.0 2018 - Paradigms shifting in tobacco dependency



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December 2018

The RCPsych issued a position statement supporting the prescription of varenicline when clinically indicated for patients with severe mental illness to support a quit attempt. The position statement also supports the use of e-cigarettes as an aid alongside other stop smoking interventions.

RCPsych position statement:

https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/ps05_18.pdf?sfvrsn=2bb7fdfe_2.

July 2018

- APS national smoking prevalence figures for 2017 released.
- BLF released a report on FP10 prescribing of stop smoking medications across all the English CCGs

June 2018

Smoking in the media:

The BBC asked “Do you know what you’re smoking?”

<https://www.bbc.co.uk/news/av/uk-44264103/do-you-know-what-you-re-smoking>

Royal College of Physicians launches Hiding in plain sight:

treating tobacco dependency in the NHS

<https://www.rcplondon.ac.uk/projects/outputs/hiding-plain-sight-treating-tobacco-dependency-nhs>

May 2018

NICE consultation:

Tobacco suite: prevention, cessation and harm reduction (update)

[https://www.nice.org.uk/guidance/GID-](https://www.nice.org.uk/guidance/GID-NG10086/documents/equality-impact-assessment)

[NG10086/documents/equality-impact-assessment](https://www.nice.org.uk/guidance/GID-NG10086/documents/equality-impact-assessment)

5.0 Where can I go for more information and resources?

- **British Thoracic Society Audit and Quality Improvement Tool**
<https://www.brit-thoracic.org.uk/standards-of-care/quality-improvement/smoking-cessation/>
- **NHS Smokefree Pledge and Briefing Note**
<http://smokefreeaction.org.uk/smokefree-nhs/nhs-smokefree-pledge/>
- **PHE CLear tobacco control assessments**
<https://www.gov.uk/government/publications/clear-local-tobacco-control-assessment>
- **London Clinical Senate resources**
<http://www.londonsenate.nhs.uk/helping-smokers-quit/>
- **Smoking in Pregnancy Challenge Group 'Carbon Monoxide Screening: advise for healthcare professionals**
<http://smokefreeaction.org.uk/wp-content/uploads/2017/06/38830CO2screening.pdf>
- **Test your breath: information for pregnant women**
<http://smokefreeaction.org.uk/wp-content/uploads/2017/06/38831TestYour-Breath.pdf>
- **Use of e-cigarettes in pregnancy: A guide for midwives and other healthcare professionals**
<http://smokefreeaction.org.uk/wp-content/uploads/2017/06/eCigSIP.pdf>
- **The National Centre for Smoking Cessation and Training: for online training and resources on evidence based smoking cessation:**
<http://www.ncsct.co.uk/>

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7.0 Appendices

7.1 Meet the experts



Darush Attar-Zadeh

A Pharmacist, Behaviour Change Specialist and National Public Health Trainer, Darush has specialised in the field of smoking cessation for over twenty years. Darush has presented at various national & international conferences (including the PCRS-UK, IPCRG, Clinical Pharmacy Congress, HPE Live, UKNSCC) and was asked to help review the National Training Standards for Smoking Cessation. Darush was part of the London Clinical Senate Helping Smokers Quit programme. In his role as respiratory lead pharmacist (Barnet CCG), Darush managed to lead a medicines management service to winning the pharmacist award in respiratory services 2016 and was highly commended at the HSJ awards 2017. Darush has published more than 15 clinical papers including information on respiratory inhaler devices, smoking cessation treatments in peer-reviewed journals. The poster Darush and colleagues (Local Pharmacy Forum in North West London) presented at PCRS 2017 was recognised and achieved a best practice poster award. Darush enjoys running and raising money for respiratory & cardiac charities. One of his main missions is to reduce health inequalities caused by tobacco and spends a lot of his time teaching in deprived locations across the UK. Darush Attar-Zadeh has worked with all companies involved in licenced smoking cessation pharmacotherapies to promote evidence based behavioural support alongside medication.



Noel Baxter

Noel is an NHS GP in Southwark, London. He is the Chair of PCRS, leads the primary care workstream of the RCP national asthma and COPD audit and was a member of the recent NICE clinical guideline group for asthma management. Dr Baxter is a clinical advisor to the British Lung Foundation and Asthma UK. He was co-lead of the London respiratory strategic clinical network from 2010 until its end in September 2016 and the London Clinical Senate 'Helping smokers quit' delivery team programme that completed in August 2016.



Alex Bobak

Dr Alex Bobak is a GP in Wandsworth, London. He started running specialist stop smoking clinics in 2001 and became the first GPSI in smoking cessation in the UK. His main interests are the optimisation of the delivery of smoking cessation and teaching the subject to health-care professionals. He was one of the pioneers of the development of very brief advice (VBA) by GPs to smokers and has carried out research into the pharmacological treatment of smoking and into how smoking cessation is taught to GP trainees. His work as a media doctor is now entirely focused on his campaign to promote evidence-based smoking cessation and anything that helps with tobacco control.



Hazel Cheeseman

Hazel Cheeseman is Director of Policy at ASH and has worked across health and social care policy in the UK and abroad. With a background in health and housing policy Hazel has particular expertise in local government and the delivery of policy at a local level. Hazel also co-ordinates two coalitions dedicated to addressing the health inequalities caused by smoking; The Smoking in Pregnancy Challenge Group and the Mental Health and Smoking Partnership.



Rachael Hodges

Rachael Hodges is the tobacco policy lead at the BLF. Her role involves shaping policy in key areas including smoking cessation services and e-cigarettes. Rachael works with the UK government, and organisations such as the NHS, to make sure policy is evidence based and has considered the voices of patients. Before joining the BLF in 2017, she worked for a health equalities charity where she helped make sure health services met the needs of LGBT people.



Steve Holmes

Dr Steve Holmes has worked as a GP for more than 30 years – and works as a part-time partner in Shepton Mallet in Somerset. Dr Holmes is education lead for PCRS-UK and is a previous chair; he has been on RCGP council for the last 10 years and has worked extensively with the British Thoracic Society, British Lung Foundation and RCGP with more than 200 publications to his name. Dr Holmes is passionate that evidence based, patient centred care will improve outcomes and the quality of life of our patients. Dr Holmes is married with two daughters.



Duncan Keeley

Duncan Keeley is Policy Lead on the Executive Committee of the Primary Care Respiratory Society – UK. He has special interests in respiratory medicine and medical education. He now works as a portfolio GP and GP appraiser after 24 years as a GP principal at the Rycote Practice in Thame, Oxfordshire. He is an honorary tutor in general practice at the Department of Primary Care, University of Oxford. He was a GP Trainer from 1995 – 2013. He studied medicine at Cambridge University and The London Hospital. He trained in general medicine and paediatrics in London and then spent three years working as a paediatrician at Harare Central and Chitungwiza hospitals in Zimbabwe before entering general practice. He was an editorial adviser for the British Medical Journal from 1991 – 2001. He was a member of the Ethics Committee of the Royal College of General Practitioners from 2007-2013.



Andy McEwen

Andy worked as a nurse in acute and forensic psychiatry before specialising in the field of substance misuse treatment. In 1997 he completed an MSc in Addictive Behaviour at St George's Hospital Medical School before beginning his clinical and then academic career in smoking cessation there with Professor Robert West. In 2003 he took up post as Assistant Director of Tobacco Studies and Senior Research Nurse at the Cancer Research UK Health Behaviour Research Centre, University College London and in 2005 received a PhD for his thesis, Smoking Cessation in General Practice. Andy has published over 120 papers in academic peer-reviewed journals. Since 2010 Andy has been Chief Executive of the National Centre for Smoking Cessation and Training.

Andy McEwen has received travel funding, honorariums and consultancy payments from manufacturers of smoking cessation products (Pfizer Ltd, Novartis UK and GSK Consumer Healthcare Ltd) and hospitality from North51 who provide online and database services. He also receives payment for providing training to smoking cessation specialists and receives royalties from books on smoking cessation. Andy is an associate member of the New Nicotine Alliance (NNA), a charity that works to foster greater understanding of safer nicotine products and technologies.



Oonagh Potts

Oonagh is a highly experienced nurse practitioner, independent / supplementary prescriber. She works in general practice supporting with patients with a range of complex and long-term conditions. She is passionate about patient empowerment, education and patients being equal participants in their care management. As a training practice she has an enthusiasm to support learners and student nurses through mentorship. In addition to her clinical caseload she continues working as a free-lance as regional trainer for Education for Health and is an elected member of PCRS- UK executive committee. She also sits on the service development committee and tobacco dependency group campaigning to establish tobacco dependency as a long-term relapsing condition. She chairs a local respiratory multidisciplinary group in her area which is affiliated to PCRS-UK supporting education to HCP to give a voice in developing respiratory care pathways to optimise patient outcomes and transformational change.



Louise Restrict

Louise Restrict works as an integrated respiratory physician in inner London, co-led the London Respiratory Team/Network 2010-16, and was a member of the London Senate 'Helping Smokers Quit' team 2014-16. She co-leads the Whittington Health multi-disciplinary respiratory team and works with colleagues in Islington and Haringey. This team uses value as a framework, and is committed to reducing health inequalities, hence has a long-standing focus on reducing the impact of tobacco dependence. Her own first experience of 'smoking cessation' training was not until several years into working as consultant respiratory physician and she has advocated for the value of both 'smoking cessation' training, and motivational interviewing training, for clinicians since then. She now leads a team where all members are trained in diagnosing and treating tobacco dependence.



Ailsa Rutter OBE

Ailsa originally trained as a nurse in London (BSc Hons Kings College, London) and has worked in tobacco control since 1998 when she got the 'bug' during her time living and studying (MSc Health Sciences, Queensland University of Technology) in Australia in the 1990s. Her first tobacco post was heading up the Queensland Quit Campaign where she was involved in the world-renowned National Tobacco Campaign. On her return to the UK she managed the Gateshead and South Tyneside NHS Stop Smoking Service until 2004 before taking up the post of Department of Health Regional Tobacco Manager for the North East. In 2005 Ailsa working with others launched Fresh- Smoke Free North East – the UK's first regional tobacco control programme- and has been its Director ever since. In 2014 Ailsa was awarded a World No Tobacco Day Medal by the World Health Organisation and an OBE in the New Year's Honours 2017 for 'services to tobacco control'. She is passionate about this work, having prematurely lost her father and auntie to COPD and is proud to be working with many committed partners to help achieve the vision of 'making smoking history' and reducing smoking to 5% by 2025 in the North East.



Vicky Salt

Vicky Salt is Manager at Action on Smoking and Health (UK).



Kamran Siddiqi

Kamran Siddiqi is Professor in Public Health at the University of York. Kamran has a medical background with further training in chest diseases and public health and has carried out research in the UK, Latin America and South Asia in the area of lung health. He uses quantitative research methods to evaluate public health interventions and is particularly interested in research to help control tobacco use in south Asia.



Hilary Wareing

Hilary Wareing is the Director of Improving Performance in Practice (iPiP) and the Tobacco Control Collaborating Centre (TCCC), she has a background in health service research and management as well as a clinical background as a Registered General Nurse, Midwife and Health Visitor. Hilary's main areas of interest are developing the wider public health workforce and supporting organisations to implement evidence-based practice and improve performance in practice. She is particularly interested in using an asset-based approach in the development of public health initiatives.

Hilary was involved in the implementation of Smokefree legislation in England and took a lead role in its implementation within mental health settings. The areas of work she is currently involved in includes; reducing the prevalence of smoking in pregnancy, promoting smoke-free homes and cars, secondary care, mental health and supporting local authorities to review the commissioning of services to reduce prevalence and help people to quit.

Hilary also leads the CLear peer assessment team on behalf of PHE.



Andy Whittamore

Dr Andy Whittamore is a GP and Respiratory Lead in a large multi-site practice in Portsmouth. He has previously had roles with PCRS (Executive Committee and Chair of the Conference Organising Committee), Wessex AHSN (Primary Care Lead, Respiratory Programme) and Department of Health Respiratory Programme (regional lead).

Andy currently spends two days per week as Clinical Lead for Asthma UK where he is responsible for clinical governance for the organisation and regularly contributes towards many facets of the charity's work. This includes supporting the development of digital advice and support for people with asthma, multimedia content for the website and media teams, clinical insights to the Policy and External Affairs team and clinical input into Asthma Lab which provides insight and support to innovators developing digital products that can help people with asthma.



Siân Williams

Siân Williams has an NHS management background, a public health degree and has also worked in the private sector in medical communications. She focuses on large-scale behaviour change, service improvement and value-based healthcare at an individual and population level. She has addressed this in three UK programmes: IMProving and Integrating RESpiratory Services in the NHS (IMPRESS), NHS England London Respiratory Network and the London Clinical Senate's Helping Smokers Quit programme. She is also the Chief Executive Officer of the International Primary Care Respiratory Group where she leads similar programmes in low-, middle- and high-income countries where tobacco dependence is often an even bigger challenge. This international perspective is summarised in Treating tobacco dependence: guidance for primary care on life-saving interventions. Position statement of the IPCRG, <https://rdcu.be/bcHmT> endorsed by the Member Organisations of World Organization of Family Doctors Europe.