



PCRS Pragmatic Guides for Clinicians  
Diagnosis and Management of Tobacco Dependency

# DRAFT FOR COMMENT

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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 Organisation 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 and is the responsibility of all health professionals; treating tobacco dependency should be a high priority of all clinicians.

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## 1.0 Context

### 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 do better in treating 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 fifteen 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.

### 1.3. 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.<sup>1</sup> These individuals remain at risk for the short, medium and long-term consequences of tobacco dependence.

The decline in smoking prevalence is due to successful intervention at an individual level by passionate healthcare professionals and public health interventions aimed at stopping people from taking up smoking. 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 estimated 8 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. However, 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.

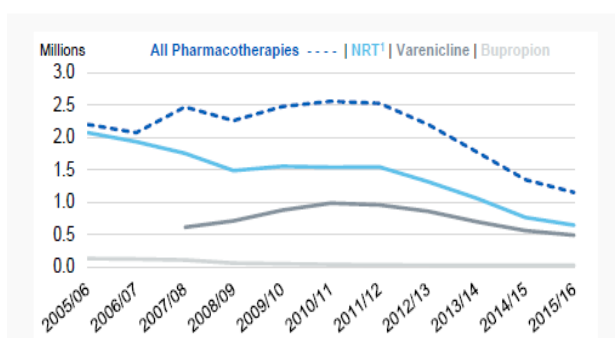
*Smoking creates a heavy burden for people working in health services. Adopting a different and evidence-based approach to diagnosis and treatment has been shown to reduce this*

The 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.

### The Annual Cost of Smoking to the NHS in England

- Primary care (2017):<sup>2</sup>
  - 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):<sup>3</sup>
  - Smoking-attributable outpatient visits: £696 million
  - 474,000 smoking-attributable admissions (4% of all admissions)
  - 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 has declined in recent years.<sup>4</sup>

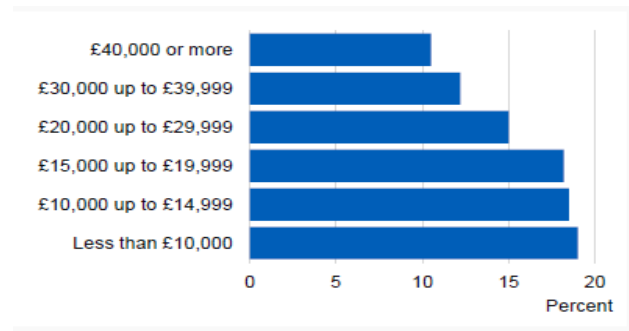
ASH/CRUK stop smoking services data from 2018 suggests that 1 in 10 GPs are no longer prescribing NRT or varenicline. The recent situation analysis from the British Lung Foundation has found that prescribed levels of NRT in the community in England have declined by 75% in recent years, far exceeding 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. 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 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*

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.<sup>5,6</sup>

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



*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.<sup>7</sup> 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*

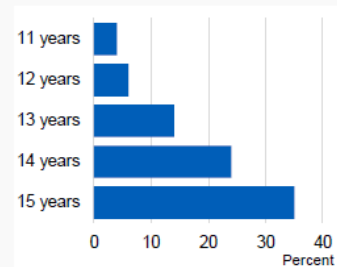
Adults with a serious mental illness have a shorter life expectancy than those without a serious mental illness. High rates of smoking among those with a serious mental illness contributes to this health inequality and yet there is good evidence that they want to quit.<sup>8</sup>

*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.**<sup>4</sup> While increasing age appears to be positively associated with quitting, a proportion of those who quit will relapse.<sup>9</sup>

**Smoking prevalence by age**

Smoking prevalence increased with age. 35% of 15 year olds had ever smoked compared to 4% of 11 year olds.



**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

### 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.

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 next health care professional, not only uses VBA approach, but also builds on previous conversation. The next encounter at which VBA is undertaken may be the one that progresses to the ACT stage and triggers a quit. 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.

These should be left to the dedicated stop smoking consultation which will hopefully follow.

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.

*“If you have an understanding of tobacco dependence, then compassion follows, and you are not judgemental” Andy McEwen, 2018*

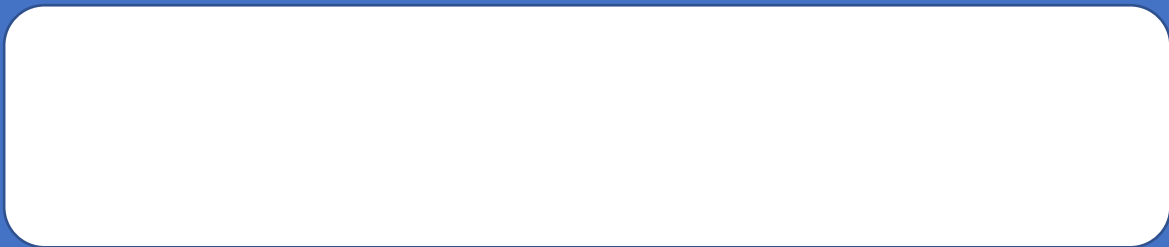
It’s important to consider also that smoking is a chronic relapsing condition so even when a patient has stopped smoking there is a risk of starting again. Ex-smokers should be asked about their smoking status until they have stopped for at least three years.

***Think about your own practice***

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



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

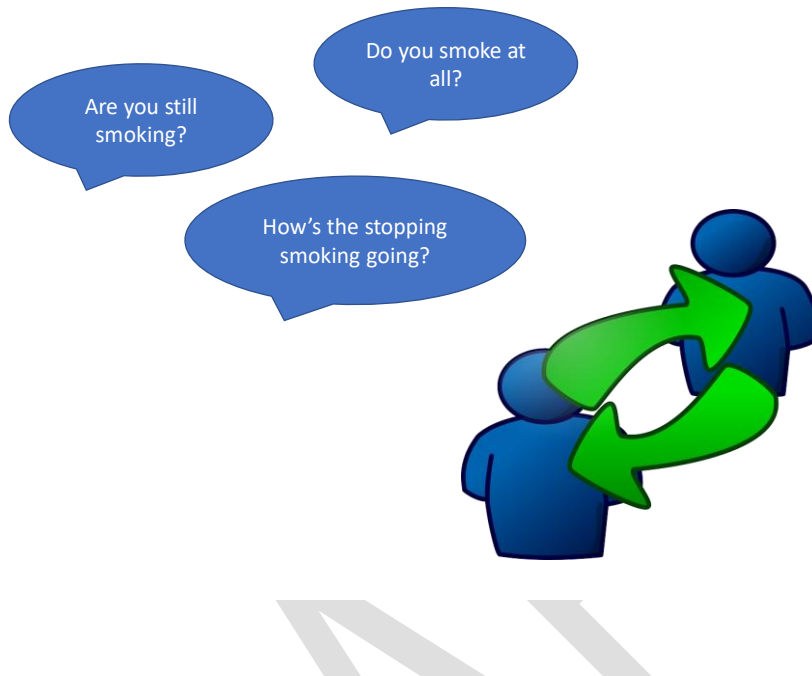


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# ASK and record smoking status

## What it is...



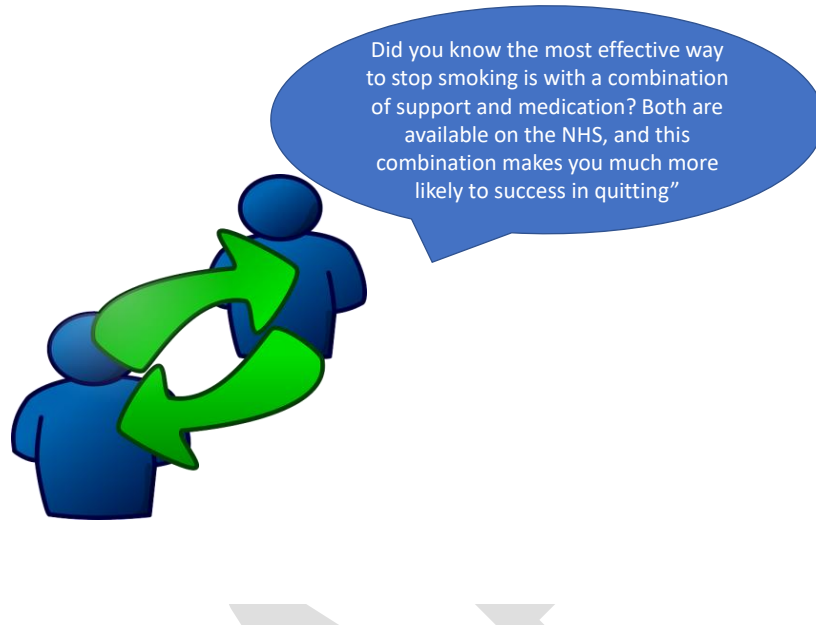
## What it is not...



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...



## What it is not...



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...



## Your patient does want to take action...



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:

[http://www.ncsct.co.uk/publication\\_very-brief-advice.php](http://www.ncsct.co.uk/publication_very-brief-advice.php)

[http://elearning.ncsct.co.uk/vba-stage\\_1](http://elearning.ncsct.co.uk/vba-stage_1)

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## 2.2 Supporting a quit attempt?

VBA is our most practical tool to trigger a quit attempt with behavioural support and medical treatment and ideally these are provided by stop smoking advisors. If smokers are unwilling or unable to attend specialist stop smoking services to quit smoking the following is a pragmatic guide for GPs to deliver a supported quit in 10-minute appointments.

### *Assessment of tobacco use*

Completing the VBA will tell you your patient's self-reported tobacco status – an important first step.

However, 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.<sup>10</sup>
- 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.

**The exhaled carbon monoxide (CO) test<sup>11</sup>** detects CO inhaled in the last 12 hours. 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. The BLF recommend a cut-off of 5 ppm or above as indicating the possibility of smoking and of 10 ppm or above as indicating the patient is a smoker.

**Cotinine test<sup>12</sup>**; may be considered as an alternative to CO testing as it is more specific for nicotine exposure. 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. Not useful for people who use NRT or e-cigarettes.

**Pack years<sup>13</sup>**; 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**

#### *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 include:

- More dependent smokers: Heaviness of smoking index (HSI) 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)

**SCORING: 0-2: low addiction 3-4: moderate addiction 5-6: high addiction**

- 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 women<sup>14</sup>

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.

## NICE recommended stop smoking interventions (as of March 2018)<sup>15</sup>

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) <sup>a</sup>	<p>12–24-week course (usually started 1–2 weeks before target stop date)</p> <ul style="list-style-type: none"> <li>• <b>Initial dose:</b> 500 micrograms for 3 days</li> <li>• <b>Then:</b> 500 micrograms twice daily for 4 days</li> <li>• <b>Then:</b> 1 mg twice daily for 11 weeks</li> </ul> <p>Effectiveness improved when used in combination with behavioural support</p>
Nicotine replacement therapy (NRT)	<p>NRT products licensed for smoking cessation in the UK include:</p> <ul style="list-style-type: none"> <li>• Dermal patch</li> <li>• Gum</li> <li>• Lozenge</li> <li>• Mini lozenge</li> <li>• Sublingual tablet</li> <li>• Inhalator</li> <li>• Nasal spray</li> <li>• Oral spray</li> <li>• Oral film</li> </ul> <p>Combination of two or more forms of NRT 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) <sup>a</sup>	<p>Adults (usually started 1–2 weeks before target stop date):</p> <ul style="list-style-type: none"> <li>• <b>Initial dose:</b> 150 mg for 6 days</li> <li>• <b>Then:</b> 150 mg twice daily for 7–9 weeks</li> <li>• <b>Discontinue</b> if abstinence not achieved at 7 weeks</li> </ul> <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

<sup>a</sup>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

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

Intervention	Strength of evidence <sup>a</sup>	Improvement in success rates when used appropriately <sup>b</sup>	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	C
Quitting with the help of e-cigarettes	C	Unknown	D
NRT obtained OTC	D	Unknown	E
Unassisted quit	E	Unknown	E

<sup>a</sup>A defines strongest supporting clinical evidence and E defines the weakest supporting clinical evidence

<sup>b</sup>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 include text messaging services, internet-based smoking cessation services and smart phone apps.

The Expert Group regards the **“Not One Puff”** rule as 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.



***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 a VBA regarding 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 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:** "OK, well if you change your mind remember we'd be really keen to help you stop and actually the gum works much better if you have someone supporting you while you use it"

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://www.ncsct.co.uk/publication\\_very-brief-advice.php](http://www.ncsct.co.uk/publication_very-brief-advice.php)
- [http://elearning.ncsct.co.uk/vba-stage\\_1](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.<sup>16,17</sup> A Cochrane review estimated that **brief advice** encouraged 1 in 40 smokers to quit<sup>18</sup> though your **ADVISE** will always 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 offer 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 21.7% higher with offer of support.

### *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 candidal 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. Would you like me to let them know?"

**ACT:** 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](http://elearning.ncsct.co.uk/vba_pregnancy-launch)
- VBA on second-hand smoke: [http://elearning.ncsct.co.uk/shs\\_vba-launch](http://elearning.ncsct.co.uk/shs_vba-launch)
- Midwifery guidance: [http://www.ncsct.co.uk/publication\\_briefing\\_for\\_midwifery\\_staff.php](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 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 a 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*

**ADVISE:** *I’m OK right now and anyway I’m going to start using e-cigarettes and maybe quit like that.* “Great, I know a lot of people have found this a useful route to quitting. Have you got an e-cigarette yet? I hope that e-cigarettes work for you but remember that you can always come back to me and we can arrange medication and support from the local service”

**ACT:** Record in Adam’s notes that **VBA** was delivered, and that Adam intends to make a quit attempt using **e-cigarettes**. Tell him that if he changes his mind that support is always available. Schedule a follow-up visit and 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](http://www.ncsct.co.uk/publication_mental_health_briefing.php)

#### **Expert commentary:**

Smoking rates are significantly higher among individuals with mental health condition than among the general population. **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. Patients should be advised to stop smoking combustible tobacco completely.

If Adam does choose to use a stop smoking service, he should expect support regardless of e-cigarette use and he will also be offered varenicline which is as safe in people with stable bipolar disorder and schizophrenia as in the general population.

*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 referral made to a **stop smoking service**. Record in the discharge letter so his GP surgery can continue to support

**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.<sup>19</sup> 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 passed away 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, possibly including some **motivational interviewing** 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/NCST%20STP.pdf>
- <https://www.nice.org.uk/guidance/ng92/>
- <https://bnf.nice.org.uk/drug/varenicline.html>
- <https://www.theiprg.org/display/TreatP/Video+clips+and+link+to+Vimeo+channel> (for pulmonary rehabilitation)

**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%**.<sup>20</sup> 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 as 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. Difficult clinical questions, conversations and responses – The expert panel responds

**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?**

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 – evidence that sequential intervention has better outcomes. This works for most people most of the time

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

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

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

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. The first step is to deliver VBA and support. The next time you deliver VBA might be the time the patient motivation is there and a quit is attempted

**My patient also smokes marijuana, will VBA work?**

Your patient's cannabis use will have to be directly addressed if they decide to quit smoking. Advising 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 generally are rather limited.

**How does VBA differ from motivational interviewing?**

VBA 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 is a tool that could be used in the follow-up specialist consultation. Motivational interviewing requires more intensive training for effective delivery. Neither VBA or MI should be delivered without training.

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

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. Risk of one cigarette per day has been shown to be half that of 20 per day.



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**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 diktats such as this in the interests of patient focused care?**

In England, this situation has arisen as 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. Irrespective of local guidance, pharmacotherapy should be prescribed where clinically indicated

**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?**

As an expert group we are not currently in a position to make any recommendations in this respect. 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. A number of 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](http://elearning.ncsct.co.uk/e_cigarettes-launch)

[https://www.youtube.com/playlist?list=PLvBx3\\_9F8cFmB6Y\\_pWsawuQhdy-x\\_1i4K](https://www.youtube.com/playlist?list=PLvBx3_9F8cFmB6Y_pWsawuQhdy-x_1i4K)

[http://www.ncsct.co.uk/publication\\_electronic\\_cigarette\\_briefing.php](http://www.ncsct.co.uk/publication_electronic_cigarette_briefing.php)

**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**

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

**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**

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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 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?**

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).

**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?**

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.

**Is it worth getting an exhaled carbon monoxide monitor?**

Yes. It can be a powerful motivational tool. See the Helping Smokers Quit in London advice on exhaled CO: <http://www.londonsenate.nhs.uk/wp-content/uploads/2015/04/The-expired-carbon-monoxide-CO-test-guidance-for-health-professionals.pdf>

**When and for whom should I consider prescribing varenicline?**

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

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

## 6. What's new in 2018?

### 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-NG10086/documents/equality-impact-assessment>

## 7. 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 breathe: information for pregnant women <http://smokefreeaction.org.uk/wp-content/uploads/2017/06/38831TestYourBreath.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/>

## 8. References

1. <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/adultsmokinghabitsingreatbritain/2017>
2. <https://www.gov.uk/government/publications/cost-of-smoking-to-the-nhs-in-england-2015/cost-of-smoking-to-the-nhs-in-england-2015>
3. <https://www.rcplondon.ac.uk/projects/outputs/hiding-plain-sight-treating-tobacco-dependency-nhs>
4. <http://digital.nhs.uk/catalogue/PUB24228>
5. <https://files.digital.nhs.uk/publication/d/i/smok-eng-2017-rep.pdf>
6. <http://socialmetricscommission.org.uk/MEASURING-POVERTY-SUMMARY-REPORT.pdf>
7. [http://www.ncsct.co.uk/publication\\_stop\\_smoking\\_services\\_and\\_health\\_inequalities.php](http://www.ncsct.co.uk/publication_stop_smoking_services_and_health_inequalities.php)
8. [http://www.ncsct.co.uk/usr/pdf/mental\\_health\\_briefing\\_A4.pdf](http://www.ncsct.co.uk/usr/pdf/mental_health_briefing_A4.pdf);  
<http://ash.org.uk/information-and-resources/reports-submissions/reports/the-stolen-years/>
9. Samim D, Mean M, Clair C, et al. A 10-year observational study on the trends and determinants of smoking status. PLoS ONE 2018;13:e0200010
10. Smoking in Pregnancy Challenge Group Report; <http://smokefreeaction.org.uk/smokefree-nhs/smoking-in-pregnancy-challenge-group/>
11. <https://www.blf.org.uk/support-for-you/breathing-tests/exhaled-carbon-monoxide-test>
12. <https://labtestsonline.org.uk/tests/nicotinecotinine>
13. <https://www.smokingpackyears.com/>
14. <https://digital.nhs.uk/media/21940/Infant-Feeding-Survey-UK-2010-Chapter-11-Dietary-supplements-smoking-and-drinking/Any/ifs-uk-2010-chap11-diet-supp-smok-drink>
15. <https://www.nice.org.uk/guidance/ng92/chapter/recommendations#behavioural-support>
16. Hun WT, et al. Use and perceived helpfulness of smoking cessation methods: results from a population survey of recent quitters. BMC Public Health 2011;11:592.
17. Soulakova JN, Crockett LJ. Unassisted quitting and smoking cessation methods used in the United States: Analyses of 2010-2011 tobacco use supplement to the current population survey data. Nicotine Tob Res 2017;20:30–39.
18. Coleman T. ABC of smoking cessation: Use of simple advice and behavioural support. BMJ (Online) 2004;328:397–9.
19. [http://www.ncsct.co.uk/usr/pub/LSSS\\_service\\_delivery\\_guidance.pdf](http://www.ncsct.co.uk/usr/pub/LSSS_service_delivery_guidance.pdf)
20. <https://gpcontract.co.uk>

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